Actuarial Memorandum

Tufts Associated Health Maintenance Organizations, Inc. and Tufts Insurance Company
Rhode Island Small Group and Large Group – Trend Development

The purpose of this actuarial memorandum is to file trend factors for Tufts Health Plan (THP) to be effective January 1, 2013.

Since THP's claims experience in Rhode Island is not sufficiently credible to support the development of RI trend factors, we used the same methodology in developing 2013 trends as what was used in our previous filings. The utilization trends are based on Massachusetts utilization trends, which are developed using 36 months of historical utilization experience in over 40 different service categories. Utilization trends are adjusted for changes in mix of service, demographics and business mix. The medical unit cost trends are based on the existing Rhode Island provider contracts and a best estimate of unit cost increases for those provider contracts that are still outstanding. The Rhode Island Rx unit cost trend is the same as the Massachusetts Rx unit cost trend since our Rx contract does not differ by state.

In June 2012, a new Rx contract will be signed with our Pharmacy vendor, Caremark. The new Rx contract will reduce Rx costs significantly. In order to pass these savings on to members as they occur, THP is revising our 2012 Rx trend to incorporate the terms of the new pharmacy contract effective May 2012. With this revised Rx trend, the total 2012 trend is reduced by 1.2% compared to the trend previously filed and approved for 2012.

Proposed 2012 trend factors:

	IP	OP	Primary Care	Other M/S	Autism Mandate	Rx	Weighted Total
Total	5.9%	7.6%	6.4%	4.8%	0.2%	0.3%	5.3%
Price Only	3.6%	3.7%	4.1%	1.3%		-3.6%	1.9%
Utilization	2.2%	3.8%	2.2%	3.5%		4.0%	3.3%

Previously approved 2012 trend factors:

	IP	OP	Primary Care	Other M/S	Autism Mandate	Rx	Weighted Total
Total	5.9%	7.6%	6.4%	4.8%	0.2%	7.2%	6.5%
Price Only	3.6%	3.7%	4.1%	1.3%		3.1%	3.1%
Utilization	2.2%	3.8%	2.2%	3.5%		4.0%	3.3%

The proposed 2013 trend factors below reflect the reduced utilization trend underlying the most recent Massachusetts emerging experience. 2013 unit cost trends are based on the most updated Rhode Island provider contracts. THP's overall 2013 annual claim trend is 5.4%. The proposed 2013 trend factors are:

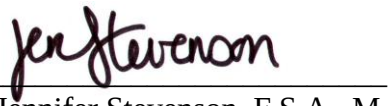
	IP	OP	Primary Care	Other M/S	Rx	Weighted Total
Total	5.2%	6.7%	5.4%	4.7%	4.7%	5.4%
Price Only	3.6%	3.4%	3.3%	1.8%	0.8%	2.6%
Utilization	1.5%	3.2%	2.0%	2.9%	3.9%	2.8%

To the extent that the offsetting impact of our 2012 trend reduction is not considered when evaluating our 2013 trend against the 4% target, Tufts Health Plan may need to reconsider the timing of implementing the new Caremark contract, which could result in changes to both our 2012 and 2013 trends.

We have elected, again, not to reflect the actual projected administrative charges in our RI business, but rather, have assumed the administration charges of a fully mature block of business. Previous filings showed 8% administrative charges, which excluded medical administration costs. In this filing, we have added medical administration to reduced administrative charges, resulting in total administrative charges of 8.6%. In addition to the administrative charges included in previous filings, the Patient Centered Outcome Research Institute (PCORI) assessment fees, and the Patient Protection and Affordable Care Act (PPACA) tax, to be paid in CY 2014 based on CY 2013 premiums, are included in premium rates effective on or after January 1, 2013. The PPACA tax and PCORI fee are evaluated at a total of about 0.7% of premium. In accordance with the May 7, 2012 OHIC letter, we are also including a version of this filing excluding the PPACA tax.

The premium rate increases shown in the filing are developed by comparing the trended manual rate for each month and the manual rate for the same month in the previous year. The proposed 2012 rate increases reflect the impact of the reduced 2012 trend.

I certify that the proposed trend factors were developed using sound actuarial assumptions and methodologies.



Jennifer Stevenson, F.S.A., M.A.A.A.
Analytic Manager
Tufts Health Plan
May 18, 2012

Tufts Associated Health Maintenance Organizations, Inc.

Small Group Rate Filing -- Effective Date January 1, 2013

Part 1. Historical Information

Experience Period for Developing Rates	
From	**To**
01/01/2009	12/31/2011

Utilization/Experience Data by Quarter (Last 12 Available Quarters)

Quarter	End Date	IP Days	Member Months	Earned Premium	Incurred Claims Total	Incurred Claims IP	Incurred Claims OP	Incurred Claims Primary Care	Incurred Claims Other M/S	Incurred Claims Rx	Loss Ratio	Quality Improvement Expense*	Other Cost Containment Expense*	Other Claim Adjustment Expense*	Other Operating Expense*	Investment Income Credit	Commissions	Contribution to Reserves
1 (Oldest)	03/31/2009	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	06/30/2009	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	09/30/2009	5	606	$191,989	$179,755	$18,154	$29,796	$10,316	$101,355	$20,134	95.9%	$4,344	$2,127	$3,714	$21,335	N/A	$8,222	($27,509)
4	12/31/2009	14	1,276	$402,183	$298,747	$51,528	$53,724	$33,981	$110,223	$49,291	76.6%	$9,146	$4,480	$7,821	$44,924	N/A	$17,313	$19,753
5	03/31/2010	20	1,524	$478,085	$399,388	$60,312	$86,443	$39,178	$150,270	$63,186	85.7%	$10,487	$4,915	$8,581	$40,284	N/A	$29,053	($14,622)
6	06/30/2010	32	1,706	$541,343	$463,611	$103,913	$110,615	$37,347	$137,711	$74,024	87.8%	$11,739	$5,502	$9,605	$45,095	N/A	$32,522	($26,732)
7	09/30/2010	42	1,417	$468,684	$386,346	$85,426	$105,558	$29,809	$100,668	$64,885	84.5%	$9,751	$4,570	$7,978	$37,456	N/A	$27,013	($4,429)
8	12/31/2010	3	1,198	$426,511	$278,535	$7,440	$67,702	$26,895	$117,412	$59,085	67.2%	$8,244	$3,863	$6,745	$31,667	N/A	$22,838	$74,619
9	03/31/2011	14	1,198	$440,948	$274,894	$21,063	$51,148	$36,189	$98,135	$68,360	64.1%	$7,868	$7,531	$7,488	$31,687	N/A	$15,903	$95,576
10	06/30/2011	8	1,174	$440,254	$316,418	$11,200	$106,006	$31,014	$99,789	$68,409	73.6%	$7,710	$7,380	$7,338	$31,053	N/A	$15,584	$54,770
11	09/30/2011	20	1,125	$431,534	$343,239	$58,259	$82,706	$32,198	$99,413	$70,663	81.3%	$7,388	$7,072	$7,032	$29,757	N/A	$14,934	$22,113
12	12/31/2011	21	1,120	$465,884	$335,312	$41,401	$93,417	$29,835	$101,530	$69,129	73.6%	$7,356	$7,041	$7,001	$29,624	N/A	$14,867	$64,684

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3- Analysis of Expenses and/or to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1

If any of the historical information reported is different from that period as reported in the prior rate filing, please provide a reconciliation and explanation showing the amount of each element of difference.

Notes:
1. The Other Operating Expenses shown above include taxes, licenses and fees, which were excluded in previous filings for the same time periods
2. Primary care claims definition has been revised to match the Primary Care Spend report
3. Expenses such as network access fee, COB and claims interest are moved from Other M/S claims to administrative expenses according to NAIC definition
4. Claims Total differences from the previous filings for the same time periods are due to updated IBNR factors that reflect more up to date claims payment, as well as the revision to the Other M/S claims definition
5. Loss ratio is calculated as (Incurred Claims Total + Quality Improvement Expense) / Earned Premium

Part 2. Prospective Information

A. 2013 Trend Factors for Projection Purposes (Annualized)

	IP	OP	Primary Care	Other M/S	Rx	Weighted Total
Total	5.2%	6.7%	5.4%	4.7%	4.7%	5.4%
Price Only	3.6%	3.4%	3.3%	1.8%	0.8%	2.6%
Utilization	1.5%	3.2%	2.0%	2.9%	3.9%	2.8%
Other**						
Other**						
Other**						
Weights	20.4%	26.5%	9.4%	26.3%	17.4%	**100%**

** All elements should add or compound to the total. If anything is to be reported as "Other" please provide a description.

2012 Trend Factors for Projection Purposes (Annualized)

	IP	OP	Primary Care	Other M/S	Autism Mandate	Rx	Weighted Total
Total	5.9%	7.6%	6.4%	4.8%	0.2%	0.3%	5.3%
Price Only	3.6%	3.7%	4.1%	1.3%		-3.6%	1.9%
Utilization	2.2%	3.8%	2.2%	3.5%		4.0%	3.3%
Other**							
Other**							
Other**							
Weights	20.2%	24.7%	8.4%	29.3%		17.4%	**100%**

** All elements should add or compound to the total. If anything is to be reported as "Other" please provide a description.

B. The following items for the period to which the rate filing applies, by quarter:

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %
1	01/01/2013	6.8%	85.2%	0.0%	1.6%	1.4%	1.4%	4.2%	3.5%	0.0%	2.7%
2	04/01/2013	6.5%	85.2%	0.0%	1.6%	1.4%	1.4%	4.2%	3.5%	0.0%	2.7%
3	07/01/2013	6.6%	85.2%	0.0%	1.6%	1.4%	1.4%	4.2%	3.5%	0.0%	2.7%
4	10/01/2013	6.8%	85.2%	0.0%	1.6%	1.4%	1.4%	4.2%	3.5%	0.0%	2.7%
Weighted Average		6.7%	85.2%	0.0%	1.6%	1.4%	1.4%	4.2%	3.5%	0.0%	2.7%

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %
1	01/01/2012	3.4%	86.5%	0.0%	0.9%	0.7%	1.3%	5.1%	3.5%	0.0%	2.0%
2	04/01/2012	3.0%	86.5%	0.0%	0.9%	0.7%	1.3%	5.1%	3.5%	0.0%	2.0%
3	07/01/2012	4.0%	86.5%	0.0%	0.9%	0.7%	1.3%	5.1%	3.5%	0.0%	2.0%
4	10/01/2012	6.6%	86.5%	0.0%	0.9%	0.7%	1.3%	5.1%	3.5%	0.0%	2.0%
Weighted Average		4.2%	86.5%	0.0%	0.9%	0.7%	1.3%	5.1%	3.5%	0.0%	2.0%

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3 - Analysis of Expenses and to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1
The sum of the expenses, commissions, contributions to reserves, investment income credit, taxes and the medical loss ratio should be 100%.

C. Average Rate Increase Components

The following items should reconcile to the Weighted Average Percent Rate Increase for the year:

	Price	Utilization, Mix	Total
Hospital Inpatient Price	0.6%	0.3%	0.9%
Hospital Outpatient	0.8%	0.7%	1.5%
Primary Care	0.3%	0.2%	0.4%
Med/Surg Other Than Primary Care	0.4%	0.6%	1.0%
Pharmacy	0.1%	0.6%	0.7%
Administrative Expense (Aggregated)			0.7%
Contribution to Reserves			0.0%
Taxes and Assessments			0.9%
Legally Mandated Changes			0.0%
Prior Period Adjustment (+/-)			0.6%
Total			6.7%

Note:
1. Due to the lack of credible experience, manual rates are developed by trending forward prior base rates to reflect trend changes. Therefore, depending on the timing of trend change, rate increases may be different from trend increase. The difference is reflected as Prior Period Adjustment above.

Part 3. Retrospective Reconciliation of Experience with Filed Factors

	Filed Data[1]					PMPM Increase[2]		Standard Plan PMPM[3]		Standard Plan Increase[4]		Approved		Loss Ratio	
Year	Member Months	Earned Premium	Incurred Claims Total	Premium PMPM	Claims PMPM	Premium	Claims	Premium	Claims	Premium	Claims	Trend Increase%	Contrib to Reserves%	Actual%	Filed%
2009	1,882	594,171	491,991	$315.71	$261.42			364.45	177.10			9.7%	0%	82.8%	87.0%
2010	5,845	1,914,623	1,568,101	$327.57	$268.28	3.8%	2.6%	376.09	286.57	3.2%	61.8%	9.5%	0%	81.9%	87.0%
2011	4,617	1,778,619	1,300,186	$385.23	$281.61	17.6%	5.0%	403.61	278.08	7.3%	-3.0%	9.2%	0%	73.1%	87.4%

[1] Corresponds to historical Information data in Part 1 above
[2] Percent increase compared to prior year
[3] For most commonly held plan of benefits in 2010 and for the same plan of benefits in 2011
[4] Percent increase compared to prior year

Note:
1. Filed loss ratio for CY 2011 is the sum of the expected pure medical cost ratio and expected quality improvement expenses % in 2011 rate factor filing

Rhode Island Health Statement Supplement

Cover Sheet

Company Name	**Tufts Associated Health Maintenance Organizations & Tufts Insurance Company**		
Enter NAIC#	**95688 & 60177**	**Reporting Year**	**2011**
Enter DBR registration # (TPAs)			

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Office of the Health Insurance Commissioner
1511 Pontiac Ave, Building #69 first floor
Cranston, RI 02920
(401) 462-9517
(401) 462-9645 (fax)
HealthInsInquiry@ohic.ri.gov

Line of Business Exhibit

Field			1 Comprehensive/Major medical			2 ASO/TPA			3 Stop loss/ Excess loss/Reinsurance			4 Medicare Part C			5 Medicare Part D			6 Medicare Supplement Policies			7 Medicaid/Other public			8 Student blanket			9 Dental Only			10 Other Medical Non-Comprehensive			11 Total (Across all lines of business)		
			RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
1		**Membership Data**																																
		Number of Polices or Certificates	197	-	197	1	-	1			-			-	91		91	3	-	3			-			-			-			-	292	-	292
		Number of Covered Lives	3,936	737	4,673	299	29	328			-			-	91		91	5	-	5			-			-			-			-	4,331	766	5,097
		Member Months	48,618	8,909	57,527	603	59	662			-			-	1,062		1,062	60	-	60			-			-			-			-	50,343	8,968	59,311
		Number of Polices or Certificates (**Plans with PD benefits**)	197	-	197	1	-	1	-	-	-	-	-	-	91	-	91	3	-	3	-	-	-	-	-	-	-	-	-	-	-	-	292	-	292
		Number of Covered Lives (**Plans with PD benefits**)	3,936	737	4,673	299	29	328	-	-	-	-	-	-	91	-	91	5	-	5	-	-	-	-	-	-	-	-	-	-	-	-	4,331	766	5,097
		Member Months (**Plans with PD benefits**)	48,618	8,909	57,527	603	59	662	-	-	-	-	-	-	1,062	-	1,062	60	-	60	-	-	-	-	-	-	-	-	-	-	-	-	50,343	8,968	59,311
2		**Premiums/Claims**																																
		Premium	19,382,569	3,553,785	22,936,354	162,614	18,088	180,702			-			-	146,221		146,221	23,160	-	23,160			-			-			-			-	19,714,564	3,571,873	23,286,437
		Claims/Medical Expenses	17,496,249	3,228,233	20,724,482	139,151	15,072	154,222			-			-	405,690		405,690	20,052	-	20,052			-			-			-			-	18,061,142	3,243,305	21,304,446
3		**Inpatient Facility**																																
		Hospital																																
	1	In-state	3,158,748	206,043	3,364,791	17,550	-	17,550			-			-			-	-	-	-			-			-			-			-	3,176,298	206,043	3,382,341
	2	Out-of-state	540,726	359,998	900,724	-	-	-			-			-			-	-	-	-			-			-			-			-	540,726	359,998	900,724
	3	Total (Lines 1 + 2)	3,699,474	566,041	4,265,515	17,550	-	17,550	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3,717,024	566,041	4,283,065
		SNF																																
	4	In-state	33,154	5,624	38,778	-	-	-			-			-			-	-	-	-			-			-			-			-	33,154	5,624	38,778
	5	Out-of-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	6	Total (Lines 4 + 5)	33,154	5,624	38,778	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	33,154	5,624	38,778
		Other																																
	7	In-state	1,167	-	1,167	-	-	-			-			-			-	-	-	-			-			-			-			-	1,167	-	1,167
	8	Out-of-state	-	12,761	12,761	-	-	-			-			-			-	-	-	-			-			-			-			-	-	12,761	12,761
	9	Total (Lines 7 + 8)	1,167	12,761	13,928	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,167	12,761	13,928
	10	**Total Inpatient Facility (Lines 3 + 6 + 9)**	3,733,795	584,427	4,318,222	17,550	-	17,550	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3,751,345	584,427	4,335,772
4		**Outpatient Facility**																																
		Hospital																																
	11	In-state	3,352,396	210,704	3,563,100	22,675	916	23,591			-			-			-	1,633	-	1,633			-			-			-			-	3,376,704	211,620	3,588,324
	12	Out-of-state	317,396	538,951	856,347	1,088	1,834	2,922			-			-			-	-	-	-			-			-			-			-	318,484	540,785	859,269
	13	Total (Lines 11 + 12)	3,669,791	749,655	4,419,447	23,763	2,749	26,512	-	-	-	-	-	-	-	-	-	1,633	-	1,633	-	-	-	-	-	-	-	-	-	-	-	-	3,695,188	752,404	4,447,593
		SNF																																
	14	In-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	15	Out-of-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	16	Total (Lines 14 + 15)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
		Freestanding Ambulatory Care Facility																																
	17	In-state	747,250	53,967	801,218	1,893	-	1,893			-			-			-	-	-	-			-			-			-			-	749,143	53,967	803,110
	18	Out-of-state	168,850	101,890	270,740	-	4,631	4,631			-			-			-	-	-	-			-			-			-			-	168,850	106,521	275,371
	19	Total (Lines 17 +18)	916,100	155,858	1,071,958	1,893	4,631	6,524	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	917,993	160,489	1,078,482
		Other																																
	20	In-state	728,426	17,731	746,156	2,074	115	2,189			-			-			-	310	-	310			-			-			-			-	730,809	17,845	748,655
	21	Out-of-state	146,342	140,799	287,140	945	369	1,314			-			-			-	47	-	47			-			-			-			-	147,334	141,167	288,501
	22	Total (Lines 20 + 21)	874,767	158,529	1,033,296	3,019	484	3,503	-	-	-	-	-	-	-	-	-	357	-	357	-	-	-	-	-	-	-	-	-	-	-	-	878,143	159,013	1,037,156
	23	**Total Outpatient Facility (Lines 13 + 16 + 19 + 22)**	5,460,659	1,064,042	6,524,701	28,676	7,864	36,539	-	-	-	-	-	-	-	-	-	1,990	-	1,990	-	-	-	-	-	-	-	-	-	-	-	-	5,491,325	1,071,906	6,563,231
5		**Primary Care**																																
	24	**Total Primary Care**	1,115,436	219,726	1,335,162	15,201	842	16,043			-			-			-	679	-	679			-			-			-			-	1,131,316	220,567	1,351,883
6		**Pharmacy**																																
	25	**Total Pharmacy**	3,060,587	545,750	3,606,337	44,737	1,491	46,227			-			-	405,690		405,690	10,316	-	10,316			-			-			-			-	3,521,330	547,241	4,068,570
7		**Medical/Surgical other than primary care**																																
	26	In-state	2,373,477	133,824	2,507,301	17,385	1,341	18,726			-			-			-	5,354	-	5,354			-			-			-			-	2,396,216	135,165	2,531,381
	27	Out-of-state	429,183	432,394	861,577	442	1,815	2,257			-			-			-	-	-	-			-			-			-			-	429,625	434,208	863,834
	28	**Total Other Medical/Surgical (Lines 26 + 27)**	2,802,660	566,218	3,368,878	17,828	3,155	20,983	-	-	-	-	-	-	-	-	-	5,354	-	5,354	-	-	-	-	-	-	-	-	-	-	-	-	2,825,841	569,374	3,395,215
8		**All other payments to medical providers**																																
	29	**Total**	1,323,112	248,070	1,571,182	15,159	1,720	16,880			-			-			-	1,714	-	1,714			-			-			-			-	1,339,986	249,790	1,589,776

Field	Market Exhibit (For Comprehensive/Major Medical Line of Business)	1 Individual			2 Small Group			3 Large Group			4 Association			5 Trust			6 Federal Employee Health Benefit Plan			7 Other Health Market			8 Total (Across all markets)		
		RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
	Membership Data																								
	Number of Polices or Certificates	1	-	1	165	-	165	31	-	31			-			-			-			-	197	-	197
	Number of Covered Lives	1	-	1	702	140	842	3,233	597	3,830			-			-			-			-	3,936	737	4,673
1	Member Months	12	-	12	9,473	1,838	11,311	39,133	7,071	46,204			-			-			-			-	48,618	8,909	57,527
	Number of Polices or Certificates (**Plans with PD benefits**)	1	-	1	165	-	165	31	-	31	-	-	-	-	-	-	-	-	-	-	-	-	197	-	197
	Number of Covered Lives (**Plans with PD benefits**)	1	-	1	702	140	842	3,233	597	3,830	-	-	-	-	-	-	-	-	-	-	-	-	3,936	737	4,673
	Member Months (**Plans with PD benefits**)	12	-	12	9,473	1,838	11,311	39,133	7,071	46,204	-	-	-	-	-	-	-	-	-	-	-	-	48,618	8,909	57,527
	Premiums/Claims																								
2	Premium	2,874	-	2,874	3,658,257	690,328	4,348,585	15,721,439	2,863,457	18,584,896			-			-			-			-	19,382,569	3,553,785	22,936,354
	Claims/Medical Expenses	1,660	-	1,660	3,100,638	454,637	3,555,275	14,393,951	2,773,596	17,167,547			-			-			-			-	17,496,249	3,228,233	20,724,482
	Inpatient Facility																								
	Hospital																								
1	In-state	-	-	-	441,217	49,217	490,434	2,717,530	156,826	2,874,356			-			-			-			-	3,158,748	206,043	3,364,791
2	Out-of-state	-	-	-	52,816	12,154	64,969	487,911	347,844	835,755			-			-			-			-	540,726	359,998	900,724
3	Total (Lines 1 + 2)	-	-	-	494,033	61,371	555,404	3,205,441	504,670	3,710,111	-	-	-	-	-	-	-	-	-	-	-	-	3,699,474	566,041	4,265,515
	SNF																								
3 4	In-state	-	-	-	7,542	-	7,542	25,612	5,624	31,236			-			-			-			-	33,154	5,624	38,778
5	Out-of-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
6	Total (Lines 4 + 5)	-	-	-	7,542	-	7,542	25,612	5,624	31,236	-	-	-	-	-	-	-	-	-	-	-	-	33,154	5,624	38,778
	Other																								
7	In-state	-	-	-	-	-	-	1,167	-	1,167			-			-			-			-	1,167	-	1,167
8	Out-of-state	-	-	-	-	-	-	-	12,761	12,761			-			-			-			-	-	12,761	12,761
9	Total (Lines 7 + 8)	-	-	-	-	-	-	1,167	12,761	13,928	-	-	-	-	-	-	-	-	-	-	-	-	1,167	12,761	13,928
10	**Total Inpatient Facility (Lines 3 + 6 + 9)**	-	-	-	501,575	61,371	562,946	3,232,220	523,056	3,755,276	-	-	-	-	-	-	-	-	-	-	-	-	3,733,795	584,427	4,318,222
	Outpatient Facility																								
	Hospital																								
11	In-state	-	-	-	514,964	32,443	547,407	2,837,431	178,261	3,015,692			-			-			-			-	3,352,396	210,704	3,563,100
12	Out-of-state	-	-	-	117,047	54,151	171,198	200,349	484,800	685,149			-			-			-			-	317,396	538,951	856,347
13	Total (Lines 11 + 12)	-	-	-	632,011	86,594	718,605	3,037,780	663,061	3,700,842	-	-	-	-	-	-	-	-	-	-	-	-	3,669,791	749,655	4,419,447
	SNF																								
14	In-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
15	Out-of-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
4 16	Total (Lines 14 + 15)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Freestanding Ambulatory Care Facility																								
17	In-state	-	-	-	160,253	5,262	165,515	586,997	48,705	635,702			-			-			-			-	747,250	53,967	801,218
18	Out-of-state	-	-	-	42,588	11,594	54,182	126,262	90,297	216,558			-			-			-			-	168,850	101,890	270,740
19	Total (Lines 17 + 18)	-	-	-	202,841	16,856	219,698	713,259	139,002	852,260	-	-	-	-	-	-	-	-	-	-	-	-	916,100	155,858	1,071,958
	Other																								
20	In-state	1,420	-	1,420	109,081	7,179	116,260	617,925	10,551	628,476			-			-			-			-	728,426	17,731	746,156
21	Out-of-state	-	-	-	15,956	30,833	46,788	130,386	109,966	240,352			-			-			-			-	146,342	140,799	287,140
22	Total (Lines 20 + 21)	1,420	-	1,420	125,037	38,012	163,048	748,311	120,517	868,828	-	-	-	-	-	-	-	-	-	-	-	-	874,767	158,529	1,033,296
23	**Total Outpatient Facility (Lines 13 + 16 + 19 + 22)**	1,420	-	1,420	959,889	141,462	1,101,351	4,499,350	922,580	5,421,930	-	-	-	-	-	-	-	-	-	-	-	-	5,460,659	1,064,042	6,524,701

5		**Primary Care**																							
	24	**Total Primary Care**	-	-	-	236,566	66,277	302,843	878,870	153,449	1,032,319			-			-			-			-	1,115,436	219,726	1,335,162
6		**Pharmacy**																							
	25	**Total Pharmacy**			-	560,457	63,013	623,470	2,500,130	482,738	2,982,868			-			-			-			-	3,060,587	545,750	3,606,337
7		**Medical/Surgical other than primary care**																							
	26	In-state	107	-	107	500,447	25,883	526,330	1,872,922	107,942	1,980,864			-			-			-			-	2,373,477	133,824	2,507,301
	27	Out-of-state	-	-	-	100,752	54,851	155,604	328,431	377,542	705,973			-			-			-			-	429,183	432,394	861,577
	28	**Total Other Medical/Surgical (Lines 26 + 27)**	107	-	107	601,200	80,734	681,934	2,201,353	485,484	2,686,837	-	-	-	-	-	-	-	-	-	-	-	-	2,802,660	566,218	3,368,878
8		**All other payments to medical providers**																							
	29	**Total**	133	-	133	240,951	41,780	282,732	1,082,028	206,290	1,288,317			-			-			-			-	1,323,112	248,070	1,571,182

2012 Rate Review Process
Areas of Medical Expense Variation

Introductory Remarks

The stated goal of this exercise is to improve OHIC's understanding of the drivers of rising medical spending in Rhode Island by comparing the experience of the issuer's Rhode Island member base to a benchmark. For the purposes of this analysis, we have used our 2011 fully insured MA HMO experience as the benchmark. However, given the size of Tufts Health Plan's membership base in Rhode Island, the results of this comparative analysis will have limited credibility. Our relative costs by area of care have changed significantly in Rhode Island from year to year and are expected to continue to be volatile as our population in this market grows. Although we have commented on the probable causes of each variation listed, these fundamentally reflect a small, immature market compared to a much larger, more mature benchmark and should be interpreted with caution.

1. The top five areas of care, based on *per capita total dollar value* positive variation from the benchmark

Area of Care	Total Excess Spending	PMPM Excess Spending	Comments on Estimated Cause
INPATIENT ACUTE MED/SURG	$1,339,638	$23.29	Attributable to higher utilization (both admits and ALOS), rather than unit cost. High cost claimants identified as having a disproportionately large impact. The higher number of admits may be a consequence of lower than benchmark outpatient professional care.
PHARMACY - Rx MM	$717,042	$12.46	Attributable to higher utilization across tiers and therapeutic classes. Higher utilization driven by more members in RI having prescriptions filled than in the benchmark population, rather than a higher number of prescriptions per member.
OUTPATIENT LABORATORY	$558,538	$9.71	Capitation strategy applied in the benchmark population successfully contains cost.
OUTPATIENT INJECTIONS	$425,609	$7.40	Driven primarily by a difference in payment methodology between RI and the benchmark population. Injection claims in RI are reimbursed on a fee for service basis while in the benchmark population they are reimbursed on a fee for service basis or bundled into an outpatient surgery case payment. More than 50% of the higher RI utilization is associated with outpatient surgery claims, which would not be separately identified in the benchmark population.
OUTPATIENT EMERGENCY ROOM	$406,508	$7.07	Attributable primarily to a higher cost per emergency room encounter. This higher cost per encounter is driven less by higher unit cost in RI and more by the higher number of services delivered within an emergency room encounter compared to the benchmark.

2. The top five areas of care, based on *the percent of positive variation in per capita spending* from the benchmark

Area of Care	Percent of Positive Variation	Total Excess Spending	Comments on Estimated Cause
OUTPATIENT INJECTIONS	158%	$425,609	Driven primarily by a difference in payment methodology as described above.
FREE STANDING HIGH COST RADIOLOGY (MRI, PET, CT)	124%	$130,764	Higher utilization of allied health facilities, along with lower Outpatient Hospital High Cost Radiology utilization, reflects appropriate re-direction of care to lower cost providers.
OUTPATIENT LABORATORY	96%	$558,538	Capitation strategy applied in the benchmark population successfully contains cost.
INPATIENT OTHER	74%	$117,886	Driven by Mental Health/Substance Abuse services. Capitation strategy for inpatient Mental Health/Substance Abuse within the benchmark population effective at containing costs.
OUTPATIENT EMERGENCY ROOM	63%	$406,508	Attributable primarily to the number of services delivered within an emergency room encounter, as described above.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Provider Contracting Practices and Hospital Contracting Conditions Verification Questionnaire

Background

The Health Insurance Advisory Council (HIAC) to the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) has promulgated Affordability Standards for commercial health insurance issuers in Rhode Island.

Health plans will improve the affordability of health care in Rhode Island by focusing their efforts upon provider payment reform, beginning with primary care. Achievement of this goal will not add to overall medical spend in the short-term, and is expected to produce savings thereafter. Specific areas of focus in support of this goal are as follows:

1. Expand and improve the primary care infrastructure in the state—with limitations on ability to pass on cost in premiums
2. Spread Adoption of the "Chronic Care Model" Medical Home
3. Standardize electronic medical record (EMR) incentives
4. Work toward comprehensive payment reform across the delivery system

To support standard four, OHIC has previously issued six conditions for issuer contracts with hospitals in Rhode Island, to be implemented by issuers upon contract execution, renewal, or extension. These are as follows:

1. Utilize unit of service payment methodologies for both inpatient and hospital outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee for service.
2. Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index ("Index"), for all contractual and optional years covered by the contract
3. Provide the opportunity for hospitals to increase their total annual revenue for

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

commercially insured enrollment under the contract by at least additional two percentage points over the previous contract year by improving or attaining mutually agreed-to performance levels for no less than three nationally-accepted clinical quality, service quality or efficiency-based measures.

4. Include terms that define the parties' mutual obligations for greater administrative efficiencies
5. Include terms that promote and measure improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers.
6. Include terms that explicitly relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement.

The purpose of this questionnaire is to assess compliance with standard four of the Affordability Standards and to consider the responses in connection with OHIC's 2012 small and large employer group rate factor review process for commercial health insurance issuers in Rhode Island.

Directions

1. Please fill out all parts of questionnaire.
2. As no providers are identified and no financial details are solicited, none of this information will be considered proprietary or confidential. Should any information or document be considered confidential by the filer, the filer must request approval of the Health Insurance Commissioner. The request must identify the specific information or document (or portion thereof) which the filer considers confidential, accompanied by a factual and legal analysis supporting the request.
3. Questionnaire responses must be verified by filing those portions of each hospital contract which support the survey response. An index or other method of reference must be included to identify which hospital contract documentation relates to each survey response. Any contract excerpts provided will be summarized for review.
4. Please contact OHIC with any questions.

State of Rhode Island Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920-4407
(401) 462-9640
(401) 462-9645 (Fax)
www.ohic.ri.gov
THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

General comment:

Tufts Health Plan has a long standing commitment to investment in payer-provider incentive alignment, and we maintain hospital and physician incentive programs that apply to the vast majority of our network providers. As a relatively new entrant into the RI market, we are at an early stage of incorporating incentive mechanisms into our RI provider contracts. Provider incentive will be a key component of our contracting strategy as we grow our presence in the state of RI.

Tufts Health Plan requests that the information provided in response to this survey be deemed to constitute "trade secrets" within the meaning of the term in section 38-2-2(4)(i)(B) of the Rhode Island General Laws. We have included a footer stating "THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION".

Finally, due to the questionable reliability of certain information provided in our responses, which is explained in further detail below, it is Tufts Health Plan's expectation and understanding that the information provided in this Provider Survey will not be used or considered in OHIC's review of Tufts Health Plan's rates.

Part 1. Hospital Inpatient Services

- **Please fill out one row in the chart below for <u>each</u> general service institution (no specialty care, no rehab) with whom you contract in RI.**
- **Institution means hospital system if all contractual terms other than $ amounts apply identically across all inpatient facilities in the contract.**
- **Incentives refer to activities or measures resulting in additional payments by the insurer.**

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments

[1] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[2] Attach analysis and relevant documentation from contracts to demonstrate compliance status.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
1	3 Years	X DRG X Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	No	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [3]	__ admission reductions __ day reductions __ process/structural changes (e.g. discharge practices) __Others (please specify)	N/A (Contract has not been renegotiated)	
2	3 Years	x DRG x Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.5~1.0%____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
3	3 Years	__DRG __Per Diem x % of Charges __ Bundled Services	No	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

[3] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
		__ Capitation or other budgeting __Others (please specify)		incentive payments. 0.1~0.5%			
4	2 Years	__DRG x Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
5	3 Years	__DRG __Per Diem x % of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	No	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
6	3 Years	__DRG __Per Diem x % of Charges __ Bundled	No	No If yes - % of total payments for inpatient services in CY	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
		Services __ Capitation or other budgeting __Others (please specify)		2011 spent on quality incentive payments. _____			
7	1 Year	__DRG _x_Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. ____ 0-2%	_X_ admission reductions _X_ day reductions __Others (please specify)	Yes, please see attached	
8	3 Years	__DRG _x_Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

Additional Questions for Hospital Inpatient Services

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

1. List the five most common areas of quality and service incentives in your company's inpatient contracts:
(These measures apply to our hospital contracts that combine inpatient and outpatient services.)
   i. Joint Commission measures (e.g., AMI, CHF, pneumonia)
   ii. Leapfrog measures (e.g., CPOD, ICU staffing)
   iii. Prevention of "Never Events"
   iv. Surgical infection rates
   v. Readmission rates
2. Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2011 spent on quality incentive payments. 0.1~1%

3. Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2011 paid through units of service based on efficient resource use (i.e DRG, Capitation, Bundled Service or partial/global budgeting): <5%

4. Estimated Payments in first six months of CY 2011 for Inpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: See comment (add comments or caveats)

   For inpatient services Tufts Health Plan does not currently have the technical capability to benchmark to Medicare IPPS reimbursement. Conducting such analysis would require incremental time, resources and technical capabilities. Benchmarking Tufts Health Plan inpatient payments to Medicare IPPS may yield volatile and potentially unreliable results due to a) differences in reimbursement methodology (Tufts Health Plan reimburses the majority of inpatient claims on either a Per Diem or Percent of Charge basis); b) our relatively small volume of business in Rhode Island; c) mix of services; and d) chargemaster levels to some of the hospitals in Rhode Island. Additionally, it is our belief that a Medicare comparison for some hospitals that perform very specific services, like Obstetrics, will not result in a comparison that is useful and may lead to unintended and/or misinterpreted conclusions.

Other Comments on Quality/Efficiency Incentives in Hospital Inpatient Contracting:

Part 2. Hospital Outpatient Services

- **Please fill out one row in the chart below for each general service institution (no specialty care, no rehab) with whom you contract in RI.**
- **Institution means hospital system if all contractual terms other than dollar amounts apply identically across all inpatient facilities in the contract.**
- **Outpatient Services include any services not involving an admission and covered under the contract with the institution.**

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[4]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - %of total payments for inpatient services in CY 2011 spent on quality incentive payments. [5]	__ Visit/Volume Reduction __ Others (please specify)	
2	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.5~1.0%____	__ Visit/Volume Reduction __ Others (please specify)	
3	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.1~0.5%	__ Visit/Volume Reduction __ Others (please specify)	
4	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality	__ Visit/Volume Reduction __ Others (please specify)	

[4] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[5] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[4]?	Utilization Incentives in Contract: (check all that apply)	Comments
		incentive payments. _____		
5	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
6	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
7	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
8	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	

Additional Questions for Hospital Outpatient Services

1. List the five most common areas of quality and service incentives in your company's hospital outpatient contracts:

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

(These measures apply to our hospital contracts that combine inpatient and outpatient services.)

i. Joint Commission measures (e.g., AMI, CHF, pneumonia)
ii. Leapfrog measures (e.g., CPOD, ICU staffing)
iii. Prevention of "Never Events"
iv. Surgical infection rates
v. Readmission rates

2. Percent of total payments to RI Hospitals for outpatient services in CY 2011 spent on quality incentive payments. 0.1~1%

3. Percent of total payments to RI Hospitals for outpatient services in CY 2011 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): n/a

4. Estimated Payments in first six months of CY 2011 for Outpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: 222% (i.e. 122% over Medicare Reimbursement) (add comments or caveats)

   For Outpatient Services, Tufts Health Plan has the technical capabilities to perform the required benchmarking analysis to Medicare; however, we have concerns about the confidence level in the accuracy of the supplied benchmark. Our concerns are due to a) the allowed reimbursement at a claim level was compared to fee information obtained from OPPS and CMS ancillary schedules such as Clinical Lab, DME etc.; b) we are not able to reprocess our claims through an OPPS Grouper and were limited to a line level reprice based on OPPS/Ancillary fees which means that exact Medicare reimbursement can only be approximated; c) Procedures that do not have a fee on OPPS/Ancillary schedules, or are billed in a different manner to Medicare (e.g., observation) were dropped from the analysis.

   Additionally, Tufts Health Plan has concerns that the results may be skewed due to a few high-volume hospitals and the large number of providers reimbursed on a percent of charges basis – factors that may distort the data due to particular mix of services and chargemaster levels of PAF providers. Based on the concerns listed above it is our belief that a Medicare comparison might not result in a benchmark that is useful and could lead to unintended and/or misinterpreted conclusions that if made public could impact certain contract negotiations by putting upward pressure on unit costs.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Other Comments on Quality/Efficiency Incentives in Hospital Outpatient Contracting:

Part 3: Professional Groups

- **"Professional Groups" is defined as non institutional/non facility groups with a valid contract and a single tax id number.**
- **Please provide information for the top 10 groups (measured by $ paid in 2011), filling in one row per group (10 rows in the table total).**

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	Multi-specialty	x Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [7] _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services _ Others (please specify)	
2	Multi-specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
3	Multi-specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code	No If yes - % of total payments for inpatient services in CY 2011 spent	__Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care	

[6] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[7] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
		__ Full/ Partial Capitation __Other (please specify)	on quality incentive payments. _____	__ use of pharmacy services __ Others (please specify)	
4	Sub - Specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
5	Primary Care	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
6	Primary Care	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0~5%	x Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care x use of pharmacy services x Others (please specify)	Quality/Member Satisfaction
7	Sub - Specialty	_ X _ Procedure-based methodology – using CPT, plan,	No	__ Visit/Volume Reduction __use of ancillary/referred services	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
		provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments.	__ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
8	Sub - Specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
9	Multi-specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
10	Multi-specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Additional Questions for Professional Groups

1. List the five most common areas of quality and service incentives in your company's professional group contracts:
   i. HEDIS (diabetes, breast cancer screening, colonoscopy, etc.)
   ii. HCHAPS
   iii. EMR adoption
   iv. Inpatient and ER use
   v. Rx Management
2. Percent of total payments to these ten professional groups in CY 2011 spent on quality incentive payments. ___<1%_____

3. Percent of total payments to these ten professional groups in CY 2011 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): ___n/a_____

4. Estimated Payments in first six months of CY 2011 for Professional Group Services as % of what Medicare would have paid for similar set. of services: 122% (i.e. 22% over Medicare Reimbursement) (add comments or caveats)

   The analysis was conducted using a claim line level comparison between allowed reimbursement and Medicare fee information obtained from RBRVS tables as well as Medicare ancillary schedules such as clinical lab, DME etc. Anesthesia services were also included. Procedures that Medicare does not reimburse but supplies RVU information for, such as preventive medicine and consults codes, are included at the RVU level rate for the Medicare comparison. Claims lines that do not have RBRVS/Ancillary schedule information were dropped from the analysis.

   Additionally, Tufts Health Plan has concerns that the results may be skewed due to particular mix of services for providers. Based on the concerns listed above it is our belief that a Medicare comparison might not result in a benchmark that is useful and could lead to unintended and/or misinterpreted conclusions that if made public could impact certain contract negotiations by putting upward pressure on unit costs.

Other Comments on Quality/Efficiency Incentives in Professional Group Contracting:

Selected Contract Sections Showing Compliance To OHIC Conditions

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Effective for dates of service on or after January 1, 2011

Office of the Health Insurance Commissioner Conditions

Pay-For-Performance: **[Redacted]** is available for the Hospital to earn based upon quality and/or efficiency measures **[redacted]**.

Case Rates: In the event **[redacted]** parties agree to meet to discuss the potential to transition to efficiency based payment methodologies (e.g., DRG, APC) in a manner that **[redacted]**.

Administrative Efficiency: Tufts Health Plan agrees to assign a Contract Specialist to provide ongoing contract related support through the term of the agreement to help mitigate contract related issues.

The Hospital agrees to work with and communicate issues to the Contract Specialist on an ongoing basis and work in good faith to resolve contract related issues in a timely manner.

Communication: During calendar year 2011 parties agree to formalize clinical communication that promotes and measures improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers.

Public Release of Contract Terms: Parties agree to allow the public release of terms outlined in this agreement if compelled by State regulatory authorities.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

1. Please provide an excel spreadsheet in the following format, detailing the 2011 actual and 2013 requested small and large group administrative costs pmpm, allocated among the NAIC- financial statement administrative cost categories. Please explain any significant changes from the financial filing for 2011 (increases/decreases of more than five percent in a particular category).

RI Insured HMO	2011 Actual (from filed financial statements)		2013 Proposed		% Change	
	Small Group	Large Group	Small Group	Large Group	Small Group	Large Group
Total Estimated Member Months	4,509	18,246	4,480	19,600	-0.6%	7.4%
Total Estimated Premiums ($pmpm)	$378.21	$397.92	$420.71	$442.55	11.2%	11.2%
Total General Administrative Expense	$41.82	$41.20	$47.08	$44.89	12.6%	9.0%
Total Cost Containment Expense	$10.43	$9.64	$10.17	$10.17	-2.5%	5.5%
Total Other Claim Adjustment Expense ($pmpm)	$7.99	$7.38	$7.79	$7.79	-2.5%	5.5%
Breakdown of General Administrative Expense ($pmpm)						
a. Payroll and benefits	$2.94	$2.72	$2.87	$2.87	-2.5%	5.5%
b. Outsourced Services (EDP, claims etc.)	$0.09	$0.09	$0.09	$0.09	-2.5%	5.5%
c. Auditing and consulting	$8.02	$7.42	$7.82	$7.82	-2.5%	5.5%
d. Commissions	$13.59	$14.62	$15.35	$13.15	12.9%	-10.0%
e. Marketing and Advertising	$1.76	$1.63	$1.72	$1.72	-2.5%	5.5%
f. Legal Expenses	$0.17	$0.16	$0.16	$0.16	-2.5%	5.5%
g. Taxes, Licenses and Fees	$7.56	$7.96	$11.99	$11.99	58.5%	50.6%
h. Reimbursements by Uninsured Plans	$0.00	$0.00	$0.00	$0.00	0.0%	0.0%
i. Other Admin Expenses	$7.68	$6.62	$7.09	$7.09	-7.7%	7.1%

Notes

1. The expense in any given administrative category may vary from year to year due to the small size of Tufts Health Plan's HMO block of business in Rhode Island. In aggregate, however, total admin has increased less than about 3% per year.

2. Please also provide an excel spreadsheet in the following format; detailing actual calendar year 2007-2011 fully insured commercial administrative costs, in accordance with the following table. This should be consistent with the annual statement filings to OHIC for administrative costs, providing additional detail on the components of administrative costs using the categories defined by NAIC financial statement and as allocated to commercially insured business only. Specifically, the information provided should agree with the "Exhibit of Premiums, Enrollment and Utilization" and the "Analysis of Operations by Line of Business" schedules included in the Annual Statements on file with OHIC. Where there are variance, a reconciliation and explanation should be provided.

Fully Insured Commercial Administrative Cost History

RI Insured HMO	2007	2008	2009	2010	2011
Total Premiums			1,212,134	6,544,977	8,965,746
Total General Administrative Expense			192,865	732,653	940,237
General Admin Exp. Ratio			15.9%	11.2%	10.5%
Total Fully Insured Member Months			3,878	18,547	22,755
General Administrative Expense ($pmpm)			$49.73	$39.50	$41.32
Breakdown of General Administrative Expense ($pmpm)					
a. Payroll and benefits			$3.37	$2.49	$2.76
b. Outsourced Services (EDP, claims etc.)			$0.01	$0.01	$0.09
c. Auditing and consulting			$5.92	$4.93	$7.54
d. Commissions			$11.74	$16.10	$14.41
e. Marketing and Advertising			$2.52	$1.72	$1.66
f. Legal Expenses			$0.08	$0.11	$0.16
g. Taxes, Licenses and Fees			$6.25	$7.06	$7.88
h. Reimbursements by Uninsured Plans			$0.00	$0.00	$0.00
i. Other Admin Expenses			$19.85	$7.03	$6.83
Cost Containment Expense			20,663	158,478	222,967
Other Claim Adjustment Expense			27,194	151,819	170,707
Total Self Insured Member Months for all Affiliated Companies doing business in RI			113,694	0	662

Notes:

1. Total premiums for 2010 differ from the aggregate amount submitted in last year's filing, but are consistent with the individual small and large group figures submitted last year.

RI Insured HMO

3. At the request of OHIC's Health Insurance Advisory Council, please provide brief answers to the following questions

- **In general and net of new taxes and fees, why should the rate of increase in Health Plan administrative costs exceed the general inflation rate?**

  Administrative expenses in total in a given year are adjusted for inflation, membership growth or loss and increases or decreases in corporate projects, which are often driven by regulatory requirements and government mandates. As a general practice, to set administrative expense targets for the annual financial plan, fixed administrative costs are grown at an inflationary rate. Variable administrative costs are then developed by applying inflation to the variable pmpm rate and then multiplying the inflated pmpm rate by planned member months. While those are the initial steps to develop targets, each administrative function is reviewed in detail to identify potential administrative cost savings and targets are adjusted accordingly.

- **What percentage of administrative costs does your organization consider fixed for the next five years? Provide detail by expense categories.**

  For the total company, we currently consider 58% of our costs fixed as follows:

Fixed Administrative Costs by Category:	
Network Management	2%
Sales and Marketing	4%
Clinical Services	5%
Operations	5%
IT & Business Effectiveness	8%
Corporate Projects	14%
Fixed Overhead and Other	20%
Total Fixed Administrative Expenses	58%

- **What administrative services are used by fully insured members that are not used by self-insured clients (e.g. broker commissions) and what are the estimated total costs ($pmpm) for those services?**

  Administrative costs for fully insured membership include expenses associated with medical cost containment ($9.80 pmpm), whereas in most cases self-insured clients bear these costs directly. Broker commissions ($14.41 pmpm) are also not applicable to most self-insured clients.

- **What does your plan use as its pmpm benchmarks or price points for commercial insurance administrative costs and why?**

We periodically participate in the benchmarking survey used to develop the *Sherlock Expense Evaluation Reports* (SEER) which are viewed as the definitive benchmarks for the functional areas of health plan administration. The Sherlock Expense Evaluation Reports (SEER) supply comprehensive and highly granular financial and operational metrics.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Health System Improvements Survey

The State of Rhode Island Office of the Health Insurance Commissioner Regulation 2 lists standards to be used by the Health Insurance Commissioner (Commissioner) for the assessment of the conduct of commercial health insurance issuers in Rhode Island for their efforts aimed at improving the efficiency and quality of health care delivery and increasing access to health care services. The standards include the following issuer activities:

1. Directing resources, including financial contributions, toward system-wide improvements in the state's health care system related to quality, access and efficiency, including providing support to local collaboratives, organizations, and initiatives that promote these three goals

2. Participating in the development and implementation of public policy issues related to health

To assist the Commissioner in this assessment, as part of the 2012 small and large employer group rate factor review process for commercial health insurance issuers in Rhode Island, please itemize and quantify your organization's contributions of finances and other material assets to these efforts in Rhode Island in calendar year 2011 in the following table.[1]

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
Funding	Grants provided by the Tufts Health Plan Foundation and Community Relations to the following RI organizations to support wellness and safety initiatives • **Best Buddies International** *Best Buddies Intergenerational College Project* Grant Amount: $20,000 • **Mount St. Rita Health Centre** *Blessings in a Back Pack* Grant Amount: $5,000 • **Bethany Home of Rhode Island Inc.**	**$515,724**

[1] The contributions can be to any entity other than a provider to improve medical and prevention services for all Rhode Islanders and to promote a coherent, integrated, and efficient statewide health care system.

State of Rhode Island Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920-4407
(401) 462-9640
(401) 462-9645 (Fax)
www.ohic.ri.gov

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
	Bethany Home Cares Grant Amount: $43,036 • **Homefront Health Care** *HIP-SAFE (Homefront Intervention to Prevent Slips & Falls in Elders)* Grant Amount: $59,438 • **Rhode Island Free Clinic Inc.** *Healthy Lifestyles for Today and Tomorrow* Grant Amount: $60,000 • **The Providence Center** *InShape Seniors* Grant Amount: $42,000 • **Ocean State Center for Independent Living (OSCIL)** *Home Sweet Accessible Home* Grant Amount: $40,000 • **Westbay Community Action Inc.** *Elder Safety* Grant Amount: $42,000 • **Rhode Island Quality Institute** *Health Information Exchange Support* Grant Amount: $25,000 • **EMR Payments** $179,250	

Participation in RI initiatives, programs and organizations	The goals of these programs, initiatives and organizations is to improve quality and/or transform primary care in the state:
	• CSI/Beacon (Project director, project manager, and nurse case manager support) $38,329
	• Value of Resource Time in Various Programs (Estimate of $30,000 for 0.2 FTE for 2011)
	  ○ RI DOH Medical Director meetings
	  ○ RI Quality Partners Safe Transitions
	  ○ RI Senate Commission on Hospital Payment Reform
	  ○ RIQI Board of Directors
	  ○ RI CSI Beacon Executive Committee
		$68,329

Thank you for your cooperation.

Tufts Associated Health Maintenance Organizations, Inc.

Small Group Rate Filing -- Effective Date January 1, 201

Part 1. Historical Information

Experience Period for Developing Rates	
From	To
01/01/2009	12/31/2011

Utilization/Experience Data by Quarter (Last 12 Available Quarters)

Quarter	End Date	IP Days	Member Months	Earned Premium	Incurred Claims Total	Incurred Claims IP	Incurred Claims OP	Incurred Claims Primary Care	Incurred Claims Other M/S	Incurred Claims Rx	Loss Ratio	Quality Improvement Expense*	Other Cost Containment Expense*	Other Claim Adjustment Expense*	Other Operating Expense*	Investment Income Credit	Commissions	Contribution to Reserves
1 (Oldest)	03/31/2009	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	06/30/2009	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	09/30/2009	5	606	$191,989	$179,755	$18,154	$29,796	$10,316	$101,355	$20,134	95.9%	$4,344	$2,127	$3,714	$21,335	N/A	$8,222	($27,509)
4	12/31/2009	14	1,276	$402,183	$298,747	$51,528	$53,724	$33,981	$110,223	$49,291	76.6%	$9,146	$4,480	$7,821	$44,924	N/A	$17,313	$19,753
5	03/31/2010	20	1,524	$478,085	$399,388	$60,312	$86,443	$39,178	$150,270	$63,186	85.7%	$10,487	$4,915	$8,581	$40,284	N/A	$29,053	($14,622)
6	06/30/2010	32	1,706	$541,343	$463,611	$103,913	$110,615	$37,347	$137,711	$74,024	87.8%	$11,739	$5,502	$9,605	$45,095	N/A	$32,522	($26,732)
7	09/30/2010	42	1,417	$468,684	$386,346	$85,426	$105,558	$29,809	$100,668	$64,885	84.5%	$9,751	$4,570	$7,978	$37,456	N/A	$27,013	($4,429)
8	12/31/2010	3	1,198	$426,511	$278,535	$7,440	$67,702	$26,895	$117,412	$59,085	67.2%	$8,244	$3,863	$6,745	$31,667	N/A	$22,838	$74,619
9	03/31/2011	14	1,198	$440,948	$274,894	$21,063	$51,148	$36,189	$98,135	$68,360	64.1%	$7,868	$7,531	$7,488	$31,687	N/A	$15,903	$95,576
10	06/30/2011	8	1,174	$440,254	$316,418	$11,200	$106,006	$31,014	$99,789	$68,409	73.6%	$7,710	$7,380	$7,338	$31,053	N/A	$15,584	$54,770
11	09/30/2011	20	1,125	$431,534	$343,239	$58,259	$82,706	$32,198	$99,413	$70,663	81.3%	$7,388	$7,072	$7,032	$29,757	N/A	$14,934	$22,113
12	12/31/2011	21	1,120	$465,884	$335,312	$41,401	$93,417	$29,835	$101,530	$69,129	73.6%	$7,356	$7,041	$7,001	$29,624	N/A	$14,867	$64,684

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3- Analysis of Expenses and/or to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1

If any of the historical information reported is different from that period as reported in the prior rate filing, please provide a reconciliation and explanation showing the amount of each element of difference.

Notes:
1. The Other Operating Expenses shown above include taxes, licenses and fees, which were excluded in previous filings for the same time periods
2. Primary care claims definition has been revised to match the Primary Care Spend report
3. Expenses such as network access fee, COB and claims interest are moved from Other M/S claims to administrative expenses according to NAIC definition
4. Claims Total differences from the previous filings for the same time periods are due to updated IBNR factors that reflect more up to date claims payment, as well as the revision to the Other M/S claims definition
5. Loss ratio is calculated as (Incurred Claims Total + Quality Improvement Expense) / Earned Premium

Part 2. Prospective Information

A. 2013 Trend Factors for Projection Purposes (Annualized)

	IP	OP	Primary Care	Other M/S	Rx	Weighted Total
Total	5.2%	6.7%	5.4%	4.7%	4.7%	5.4%
Price Only	3.6%	3.4%	3.3%	1.8%	0.8%	2.6%
Utilization	1.5%	3.2%	2.0%	2.9%	3.9%	2.8%
Other**						
Other**						
Other**						
Weights	20.4%	26.5%	9.4%	26.3%	17.4%	100%

** All elements should add or compound to the total. If anything is to be reported as "Other" please provide a description.

2012 Trend Factors for Projection Purposes (Annualized)

	IP	OP	Primary Care	Other M/S	Autism Mandate	Rx	Weighted Total
Total	5.9%	7.6%	6.4%	4.8%	0.2%	0.3%	5.3%
Price Only	3.6%	3.7%	4.1%	1.3%		-3.6%	1.9%
Utilization	2.2%	3.8%	2.2%	3.5%		4.0%	3.3%
Other**							
Other**							
Other**							
Weights	20.2%	24.7%	8.4%	29.3%		17.4%	100%

** All elements should add or compound to the total. If anything is to be reported as "Other" please provide a description.

B. The following items for the period to which the rate filing applies, by quarter:

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %
1	01/01/2013	6.1%	85.9%	0.0%	1.6%	1.4%	1.4%	4.2%	3.5%	0.0%	2.0%
2	04/01/2013	5.8%	85.9%	0.0%	1.6%	1.4%	1.4%	4.2%	3.5%	0.0%	2.0%

3	07/01/2013	5.9%	85.9%	0.0%	1.6%	1.4%	1.4%	4.2%	3.5%	0.0%	2.0%
4	10/01/2013	6.1%	85.9%	0.0%	1.6%	1.4%	1.4%	4.2%	3.5%	0.0%	2.0%
Weighted Average		6.0%	85.9%	0.0%	1.6%	1.4%	1.4%	4.2%	3.5%	0.0%	2.0%

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %
1	01/01/2012	3.4%	86.5%	0.0%	0.9%	0.7%	1.3%	5.1%	3.5%	0.0%	2.0%
2	04/01/2012	3.0%	86.5%	0.0%	0.9%	0.7%	1.3%	5.1%	3.5%	0.0%	2.0%
3	07/01/2012	4.0%	86.5%	0.0%	0.9%	0.7%	1.3%	5.1%	3.5%	0.0%	2.0%
4	10/01/2012	6.6%	86.5%	0.0%	0.9%	0.7%	1.3%	5.1%	3.5%	0.0%	2.0%
Weighted Average		4.2%	86.5%	0.0%	0.9%	0.7%	1.3%	5.1%	3.5%	0.0%	2.0%

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3 - Analysis of Expenses and to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1
The sum of the expenses, commissions, contributions to reserves, investment income credit, taxes and the medical loss ratio should be 100%.

C. Average Rate Increase Components

The following items should reconcile to the Weighted Average Percent Rate Increase for the year:

	Price	Utilization, Mix	Total
Hospital Inpatient Price	0.6%	0.3%	0.9%
Hospital Outpatient	0.8%	0.7%	1.5%
Primary Care	0.3%	0.2%	0.4%
Med/Surg Other Than Primary Care	0.4%	0.6%	1.0%
Pharmacy	0.1%	0.6%	0.7%
Administrative Expense (Aggregated)			0.7%
Contribution to Reserves			0.0%
Taxes and Assessments			0.2%
Legally Mandated Changes			0.0%
Prior Period Adjustment (+/-)			0.6%
Total			6.0%

Note:

1. Due to the lack of credible experience, manual rates are developed by trending forward prior base rates to reflect trend changes. Therefore,
depending on the timing of trend change, rate increases may be different from trend increase. The difference is reflected as Prior Period Adjustment above.

Part 3. Retrospective Reconciliation of Experience with Filed Factors

	Filed Data[1]					PMPM Increase[2]		Standard Plan PMPM[3]		Standard Plan Increase[4]		Approved		Loss Ratio	
Year	Member Months	Earned Premium	Incurred Claims Total	Premium PMPM	Claims PMPM	Premium	Claims	Premium	Claims	Premium	Claims	Trend Increase%	Contrib to Reserves%	Actual%	Filed%
2009	1,882	594,171	491,991	$315.71	$261.42			364.45	177.10			9.7%	0%	82.8%	87.0%
2010	5,845	1,914,623	1,568,101	$327.57	$268.28	3.8%	2.6%	376.09	286.57	3.2%	61.8%	9.5%	0%	81.9%	87.0%
2011	4,617	1,778,619	1,300,186	$385.23	$281.61	17.6%	5.0%	403.61	278.08	7.3%	-3.0%	9.2%	0%	73.1%	87.4%

[1] Corresponds to historical Information data in Part 1 above
[2] Percent increase compared to prior year
[3] For most commonly held plan of benefits in 2010 and for the same plan of benefits in 2011
[4] Percent increase compared to prior year

Note:
1. Filed loss ratio for CY 2011 is the sum of the expected pure medical cost ratio and expected quality improvement expenses % in 2011 rate factor filing

Rhode Island Health Statement Supplement

Cover Sheet

Company Name	**Tufts Associated Health Maintenance Organizations & Tufts Insurance Company**		
Enter NAIC#	**95688 & 60177**	**Reporting Year**	**2011**
Enter DBR registration # (TPAs)			

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Office of the Health Insurance Commissioner
1511 Pontiac Ave, Building #69 first floor
Cranston, RI 02920
(401) 462-9517
(401) 462-9645 (fax)
HealthInsInquiry@ohic.ri.gov

Line of Business Exhibit

Field			1 Comprehensive/Major medical			2 ASO/TPA			3 Stop loss/ Excess loss/Reinsurance			4 Medicare Part C			5 Medicare Part D			6 Medicare Supplement Policies			7 Medicaid/Other public			8 Student blanket			9 Dental Only			10 Other Medical Non-Comprehensive			11 Total (Across all lines of business)		
			RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
1		**Membership Data**																																
		Number of Polices or Certificates	197	-	197	1	-	1			-			-	91		91	3	-	3			-			-			-			-	292	-	292
		Number of Covered Lives	3,936	737	4,673	299	29	328			-			-	91		91	5	-	5			-			-			-			-	4,331	766	5,097
		Member Months	48,618	8,909	57,527	603	59	662			-			-	1,062		1,062	60	-	60			-			-			-			-	50,343	8,968	59,311
		Number of Polices or Certificates (**Plans with PD benefits**)	197	-	197	1	-	1	-	-	-	-	-	-	91	-	91	3	-	3	-	-	-	-	-	-	-	-	-	-	-	-	292	-	292
		Number of Covered Lives (**Plans with PD benefits**)	3,936	737	4,673	299	29	328	-	-	-	-	-	-	91	-	91	5	-	5	-	-	-	-	-	-	-	-	-	-	-	-	4,331	766	5,097
		Member Months (**Plans with PD benefits**)	48,618	8,909	57,527	603	59	662	-	-	-	-	-	-	1,062	-	1,062	60	-	60	-	-	-	-	-	-	-	-	-	-	-	-	50,343	8,968	59,311
2		**Premiums/Claims**																																
		Premium	19,382,569	3,553,785	22,936,354	162,614	18,088	180,702			-			-	146,221		146,221	23,160	-	23,160			-			-			-			-	19,714,564	3,571,873	23,286,437
		Claims/Medical Expenses	17,496,249	3,228,233	20,724,482	139,151	15,072	154,222			-			-	405,690		405,690	20,052	-	20,052			-			-			-			-	18,061,142	3,243,305	21,304,446
3		**Inpatient Facility**																																
		Hospital																																
	1	In-state	3,158,748	206,043	3,364,791	17,550	-	17,550			-			-			-	-	-	-			-			-			-			-	3,176,298	206,043	3,382,341
	2	Out-of-state	540,726	359,998	900,724	-	-	-			-			-			-	-	-	-			-			-			-			-	540,726	359,998	900,724
	3	Total (Lines 1 + 2)	3,699,474	566,041	4,265,515	17,550	-	17,550	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3,717,024	566,041	4,283,065
		SNF																																
	4	In-state	33,154	5,624	38,778	-	-	-			-			-			-	-	-	-			-			-			-			-	33,154	5,624	38,778
	5	Out-of-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	6	Total (Lines 4 + 5)	33,154	5,624	38,778	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	33,154	5,624	38,778
		Other																																
	7	In-state	1,167	-	1,167	-	-	-			-			-			-	-	-	-			-			-			-			-	1,167	-	1,167
	8	Out-of-state	-	12,761	12,761	-	-	-			-			-			-	-	-	-			-			-			-			-	-	12,761	12,761
	9	Total (Lines 7 + 8)	1,167	12,761	13,928	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,167	12,761	13,928
	10	**Total Inpatient Facility (Lines 3 + 6 + 9)**	3,733,795	584,427	4,318,222	17,550	-	17,550	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3,751,345	584,427	4,335,772
4		**Outpatient Facility**																																
		Hospital																																
	11	In-state	3,352,396	210,704	3,563,100	22,675	916	23,591			-			-			-	1,633	-	1,633			-			-			-			-	3,376,704	211,620	3,588,324
	12	Out-of-state	317,396	538,951	856,347	1,088	1,834	2,922			-			-			-	-	-	-			-			-			-			-	318,484	540,785	859,269
	13	Total (Lines 11 + 12)	3,669,791	749,655	4,419,447	23,763	2,749	26,512	-	-	-	-	-	-	-	-	-	1,633	-	1,633	-	-	-	-	-	-	-	-	-	-	-	-	3,695,188	752,404	4,447,593
		SNF																																
	14	In-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	15	Out-of-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	16	Total (Lines 14 + 15)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
		Freestanding Ambulatory Care Facility																																
	17	In-state	747,250	53,967	801,218	1,893	-	1,893			-			-			-	-	-	-			-			-			-			-	749,143	53,967	803,110
	18	Out-of-state	168,850	101,890	270,740	-	4,631	4,631			-			-			-	-	-	-			-			-			-			-	168,850	106,521	275,371
	19	Total (Lines 17 +18)	916,100	155,858	1,071,958	1,893	4,631	6,524	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	917,993	160,489	1,078,482
		Other																																
	20	In-state	728,426	17,731	746,156	2,074	115	2,189			-			-			-	310	-	310			-			-			-			-	730,809	17,845	748,655
	21	Out-of-state	146,342	140,799	287,140	945	369	1,314			-			-			-	47	-	47			-			-			-			-	147,334	141,167	288,501
	22	Total (Lines 20 + 21)	874,767	158,529	1,033,296	3,019	484	3,503	-	-	-	-	-	-	-	-	-	357	-	357	-	-	-	-	-	-	-	-	-	-	-	-	878,143	159,013	1,037,156
	23	**Total Outpatient Facility (Lines 13 + 16 + 19 + 22)**	5,460,659	1,064,042	6,524,701	28,676	7,864	36,539	-	-	-	-	-	-	-	-	-	1,990	-	1,990	-	-	-	-	-	-	-	-	-	-	-	-	5,491,325	1,071,906	6,563,231
5		**Primary Care**																																
	24	**Total Primary Care**	1,115,436	219,726	1,335,162	15,201	842	16,043			-			-			-	679	-	679			-			-			-			-	1,131,316	220,567	1,351,883
6		**Pharmacy**																																
	25	**Total Pharmacy**	3,060,587	545,750	3,606,337	44,737	1,491	46,227			-			-	405,690		405,690	10,316	-	10,316			-			-			-			-	3,521,330	547,241	4,068,570
7		**Medical/Surgical other than primary care**																																
	26	In-state	2,373,477	133,824	2,507,301	17,385	1,341	18,726			-			-			-	5,354	-	5,354			-			-			-			-	2,396,216	135,165	2,531,381
	27	Out-of-state	429,183	432,394	861,577	442	1,815	2,257			-			-			-	-	-	-			-			-			-			-	429,625	434,208	863,834
	28	**Total Other Medical/Surgical (Lines 26 + 27)**	2,802,660	566,218	3,368,878	17,828	3,155	20,983	-	-	-	-	-	-	-	-	-	5,354	-	5,354	-	-	-	-	-	-	-	-	-	-	-	-	2,825,841	569,374	3,395,215
8		**All other payments to medical providers**																																
	29	**Total**	1,323,112	248,070	1,571,182	15,159	1,720	16,880			-			-			-	1,714	-	1,714			-			-			-			-	1,339,986	249,790	1,589,776

Field	Market Exhibit (For Comprehensive/Major Medical Line of Business)	1 Individual			2 Small Group			3 Large Group			4 Association			5 Trust			6 Federal Employee Health Benefit Plan			7 Other Health Market			8 Total (Across all markets)		
		RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
	Membership Data																								
	Number of Polices or Certificates	1	-	1	165	-	165	31	-	31			-			-			-			-	197	-	197
	Number of Covered Lives	1	-	1	702	140	842	3,233	597	3,830			-			-			-			-	3,936	737	4,673
1	Member Months	12	-	12	9,473	1,838	11,311	39,133	7,071	46,204			-			-			-			-	48,618	8,909	57,527
	Number of Polices or Certificates (**Plans with PD benefits**)	1	-	1	165	-	165	31	-	31	-	-	-	-	-	-	-	-	-	-	-	-	197	-	197
	Number of Covered Lives (**Plans with PD benefits**)	1	-	1	702	140	842	3,233	597	3,830	-	-	-	-	-	-	-	-	-	-	-	-	3,936	737	4,673
	Member Months (**Plans with PD benefits**)	12	-	12	9,473	1,838	11,311	39,133	7,071	46,204	-	-	-	-	-	-	-	-	-	-	-	-	48,618	8,909	57,527
	Premiums/Claims																								
2	Premium	2,874	-	2,874	3,658,257	690,328	4,348,585	15,721,439	2,863,457	18,584,896			-			-			-			-	19,382,569	3,553,785	22,936,354
	Claims/Medical Expenses	1,660	-	1,660	3,100,638	454,637	3,555,275	14,393,951	2,773,596	17,167,547			-			-			-			-	17,496,249	3,228,233	20,724,482
	Inpatient Facility																								
	Hospital																								
1	In-state	-	-	-	441,217	49,217	490,434	2,717,530	156,826	2,874,356			-			-			-			-	3,158,748	206,043	3,364,791
2	Out-of-state	-	-	-	52,816	12,154	64,969	487,911	347,844	835,755			-			-			-			-	540,726	359,998	900,724
3	Total (Lines 1 + 2)	-	-	-	494,033	61,371	555,404	3,205,441	504,670	3,710,111	-	-	-	-	-	-	-	-	-	-	-	-	3,699,474	566,041	4,265,515
	SNF																								
3 4	In-state	-	-	-	7,542	-	7,542	25,612	5,624	31,236			-			-			-			-	33,154	5,624	38,778
5	Out-of-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
6	Total (Lines 4 + 5)	-	-	-	7,542	-	7,542	25,612	5,624	31,236	-	-	-	-	-	-	-	-	-	-	-	-	33,154	5,624	38,778
	Other																								
7	In-state	-	-	-	-	-	-	1,167	-	1,167			-			-			-			-	1,167	-	1,167
8	Out-of-state	-	-	-	-	-	-	-	12,761	12,761			-			-			-			-	-	12,761	12,761
9	Total (Lines 7 + 8)	-	-	-	-	-	-	1,167	12,761	13,928	-	-	-	-	-	-	-	-	-	-	-	-	1,167	12,761	13,928
10	**Total Inpatient Facility (Lines 3 + 6 + 9)**	-	-	-	501,575	61,371	562,946	3,232,220	523,056	3,755,276	-	-	-	-	-	-	-	-	-	-	-	-	3,733,795	584,427	4,318,222
	Outpatient Facility																								
	Hospital																								
11	In-state	-	-	-	514,964	32,443	547,407	2,837,431	178,261	3,015,692			-			-			-			-	3,352,396	210,704	3,563,100
12	Out-of-state	-	-	-	117,047	54,151	171,198	200,349	484,800	685,149			-			-			-			-	317,396	538,951	856,347
13	Total (Lines 11 + 12)	-	-	-	632,011	86,594	718,605	3,037,780	663,061	3,700,842	-	-	-	-	-	-	-	-	-	-	-	-	3,669,791	749,655	4,419,447
	SNF																								
14	In-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
15	Out-of-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
4 16	Total (Lines 14 + 15)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Freestanding Ambulatory Care Facility																								
17	In-state	-	-	-	160,253	5,262	165,515	586,997	48,705	635,702			-			-			-			-	747,250	53,967	801,218
18	Out-of-state	-	-	-	42,588	11,594	54,182	126,262	90,297	216,558			-			-			-			-	168,850	101,890	270,740
19	Total (Lines 17 + 18)	-	-	-	202,841	16,856	219,698	713,259	139,002	852,260	-	-	-	-	-	-	-	-	-	-	-	-	916,100	155,858	1,071,958
	Other																								
20	In-state	1,420	-	1,420	109,081	7,179	116,260	617,925	10,551	628,476			-			-			-			-	728,426	17,731	746,156
21	Out-of-state	-	-	-	15,956	30,833	46,788	130,386	109,966	240,352			-			-			-			-	146,342	140,799	287,140
22	Total (Lines 20 + 21)	1,420	-	1,420	125,037	38,012	163,048	748,311	120,517	868,828	-	-	-	-	-	-	-	-	-	-	-	-	874,767	158,529	1,033,296
23	**Total Outpatient Facility (Lines 13 + 16 + 19 + 22)**	1,420	-	1,420	959,889	141,462	1,101,351	4,499,350	922,580	5,421,930	-	-	-	-	-	-	-	-	-	-	-	-	5,460,659	1,064,042	6,524,701

5		**Primary Care**																							
	24	**Total Primary Care**	-	-	-	236,566	66,277	302,843	878,870	153,449	1,032,319			-			-			-			-	1,115,436	219,726	1,335,162
6		**Pharmacy**																							
	25	**Total Pharmacy**			-	560,457	63,013	623,470	2,500,130	482,738	2,982,868			-			-			-			-	3,060,587	545,750	3,606,337
7		**Medical/Surgical other than primary care**																							
	26	In-state	107	-	107	500,447	25,883	526,330	1,872,922	107,942	1,980,864			-			-			-			-	2,373,477	133,824	2,507,301
	27	Out-of-state	-	-	-	100,752	54,851	155,604	328,431	377,542	705,973			-			-			-			-	429,183	432,394	861,577
	28	**Total Other Medical/Surgical (Lines 26 + 27)**	107	-	107	601,200	80,734	681,934	2,201,353	485,484	2,686,837	-	-	-	-	-	-	-	-	-	-	-	-	2,802,660	566,218	3,368,878
8		**All other payments to medical providers**																							
	29	**Total**	133	-	133	240,951	41,780	282,732	1,082,028	206,290	1,288,317			-			-			-			-	1,323,112	248,070	1,571,182

2012 Rate Review Process
Areas of Medical Expense Variation

Introductory Remarks

The stated goal of this exercise is to improve OHIC's understanding of the drivers of rising medical spending in Rhode Island by comparing the experience of the issuer's Rhode Island member base to a benchmark. For the purposes of this analysis, we have used our 2011 fully insured MA HMO experience as the benchmark. However, given the size of Tufts Health Plan's membership base in Rhode Island, the results of this comparative analysis will have limited credibility. Our relative costs by area of care have changed significantly in Rhode Island from year to year and are expected to continue to be volatile as our population in this market grows. Although we have commented on the probable causes of each variation listed, these fundamentally reflect a small, immature market compared to a much larger, more mature benchmark and should be interpreted with caution.

1. The top five areas of care, based on *per capita total dollar value* positive variation from the benchmark

Area of Care	Total Excess Spending	PMPM Excess Spending	Comments on Estimated Cause
INPATIENT ACUTE MED/SURG	$1,339,638	$23.29	Attributable to higher utilization (both admits and ALOS), rather than unit cost. High cost claimants identified as having a disproportionately large impact. The higher number of admits may be a consequence of lower than benchmark outpatient professional care.
PHARMACY - Rx MM	$717,042	$12.46	Attributable to higher utilization across tiers and therapeutic classes. Higher utilization driven by more members in RI having prescriptions filled than in the benchmark population, rather than a higher number of prescriptions per member.
OUTPATIENT LABORATORY	$558,538	$9.71	Capitation strategy applied in the benchmark population successfully contains cost.
OUTPATIENT INJECTIONS	$425,609	$7.40	Driven primarily by a difference in payment methodology between RI and the benchmark population. Injection claims in RI are reimbursed on a fee for service basis while in the benchmark population they are reimbursed on a fee for service basis or bundled into an outpatient surgery case payment. More than 50% of the higher RI utilization is associated with outpatient surgery claims, which would not be separately identified in the benchmark population.
OUTPATIENT EMERGENCY ROOM	$406,508	$7.07	Attributable primarily to a higher cost per emergency room encounter. This higher cost per encounter is driven less by higher unit cost in RI and more by the higher number of services delivered within an emergency room encounter compared to the benchmark.

2. The top five areas of care, based on *the percent of positive variation in per capita spending* from the benchmark

Area of Care	Percent of Positive Variation	Total Excess Spending	Comments on Estimated Cause
OUTPATIENT INJECTIONS	158%	$425,609	Driven primarily by a difference in payment methodology as described above.
FREE STANDING HIGH COST RADIOLOGY (MRI, PET, CT)	124%	$130,764	Higher utilization of allied health facilities, along with lower Outpatient Hospital High Cost Radiology utilization, reflects appropriate re-direction of care to lower cost providers.
OUTPATIENT LABORATORY	96%	$558,538	Capitation strategy applied in the benchmark population successfully contains cost.
INPATIENT OTHER	74%	$117,886	Driven by Mental Health/Substance Abuse services. Capitation strategy for inpatient Mental Health/Substance Abuse within the benchmark population effective at containing costs.
OUTPATIENT EMERGENCY ROOM	63%	$406,508	Attributable primarily to the number of services delivered within an emergency room encounter, as described above.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Provider Contracting Practices and Hospital Contracting Conditions Verification Questionnaire

Background

The Health Insurance Advisory Council (HIAC) to the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) has promulgated Affordability Standards for commercial health insurance issuers in Rhode Island.

Health plans will improve the affordability of health care in Rhode Island by focusing their efforts upon provider payment reform, beginning with primary care. Achievement of this goal will not add to overall medical spend in the short-term, and is expected to produce savings thereafter. Specific areas of focus in support of this goal are as follows:

1. Expand and improve the primary care infrastructure in the state—with limitations on ability to pass on cost in premiums
2. Spread Adoption of the "Chronic Care Model" Medical Home
3. Standardize electronic medical record (EMR) incentives
4. Work toward comprehensive payment reform across the delivery system

To support standard four, OHIC has previously issued six conditions for issuer contracts with hospitals in Rhode Island, to be implemented by issuers upon contract execution, renewal, or extension. These are as follows:

1. Utilize unit of service payment methodologies for both inpatient and hospital outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee for service.
2. Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index ("Index"), for all contractual and optional years covered by the contract
3. Provide the opportunity for hospitals to increase their total annual revenue for

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

commercially insured enrollment under the contract by at least additional two percentage points over the previous contract year by improving or attaining mutually agreed-to performance levels for no less than three nationally-accepted clinical quality, service quality or efficiency-based measures.

4. Include terms that define the parties' mutual obligations for greater administrative efficiencies
5. Include terms that promote and measure improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers.
6. Include terms that explicitly relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement.

The purpose of this questionnaire is to assess compliance with standard four of the Affordability Standards and to consider the responses in connection with OHIC's 2012 small and large employer group rate factor review process for commercial health insurance issuers in Rhode Island.

Directions

1. Please fill out all parts of questionnaire.
2. As no providers are identified and no financial details are solicited, none of this information will be considered proprietary or confidential. Should any information or document be considered confidential by the filer, the filer must request approval of the Health Insurance Commissioner. The request must identify the specific information or document (or portion thereof) which the filer considers confidential, accompanied by a factual and legal analysis supporting the request.
3. Questionnaire responses must be verified by filing those portions of each hospital contract which support the survey response. An index or other method of reference must be included to identify which hospital contract documentation relates to each survey response. Any contract excerpts provided will be summarized for review.
4. Please contact OHIC with any questions.

State of Rhode Island Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920-4407
(401) 462-9640
(401) 462-9645 (Fax)
www.ohic.ri.gov
THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

General comment:

Tufts Health Plan has a long standing commitment to investment in payer-provider incentive alignment, and we maintain hospital and physician incentive programs that apply to the vast majority of our network providers. As a relatively new entrant into the RI market, we are at an early stage of incorporating incentive mechanisms into our RI provider contracts. Provider incentive will be a key component of our contracting strategy as we grow our presence in the state of RI.

Tufts Health Plan requests that the information provided in response to this survey be deemed to constitute "trade secrets" within the meaning of the term in section 38-2-2(4)(i)(B) of the Rhode Island General Laws. We have included a footer stating "THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION".

Finally, due to the questionable reliability of certain information provided in our responses, which is explained in further detail below, it is Tufts Health Plan's expectation and understanding that the information provided in this Provider Survey will not be used or considered in OHIC's review of Tufts Health Plan's rates.

Part 1. Hospital Inpatient Services

- **Please fill out one row in the chart below for <u>each</u> general service institution (no specialty care, no rehab) with whom you contract in RI.**
- **Institution means hospital system if all contractual terms other than $ amounts apply identically across all inpatient facilities in the contract.**
- **Incentives refer to activities or measures resulting in additional payments by the insurer.**

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments

[1] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[2] Attach analysis and relevant documentation from contracts to demonstrate compliance status.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
1	3 Years	X DRG X Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	No	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [3]	__ admission reductions __ day reductions __ process/structural changes (e.g. discharge practices) __Others (please specify)	N/A (Contract has not been renegotiated)	
2	3 Years	x DRG x Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.5~1.0%____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
3	3 Years	__DRG __Per Diem x % of Charges __ Bundled Services	No	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

[3] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
		__ Capitation or other budgeting __Others (please specify)		incentive payments. 0.1~0.5%			
4	2 Years	__DRG x Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
5	3 Years	__DRG __Per Diem x % of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	No	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
6	3 Years	__DRG __Per Diem x % of Charges __ Bundled	No	No If yes - % of total payments for inpatient services in CY	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
		Services __ Capitation or other budgeting __Others (please specify)		2011 spent on quality incentive payments. _____			
7	1 Year	__DRG _x_Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. ____ 0-2%	_X_ admission reductions _X_ day reductions __Others (please specify)	Yes, please see attached	
8	3 Years	__DRG _x_Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

Additional Questions for Hospital Inpatient Services

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

1. List the five most common areas of quality and service incentives in your company's inpatient contracts:
(These measures apply to our hospital contracts that combine inpatient and outpatient services.)
   i. Joint Commission measures (e.g., AMI, CHF, pneumonia)
   ii. Leapfrog measures (e.g., CPOD, ICU staffing)
   iii. Prevention of "Never Events"
   iv. Surgical infection rates
   v. Readmission rates
2. Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2011 spent on quality incentive payments. 0.1~1%

3. Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2011 paid through units of service based on efficient resource use (i.e DRG, Capitation, Bundled Service or partial/global budgeting): <5%

4. Estimated Payments in first six months of CY 2011 for Inpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: See comment (add comments or caveats)

   For inpatient services Tufts Health Plan does not currently have the technical capability to benchmark to Medicare IPPS reimbursement. Conducting such analysis would require incremental time, resources and technical capabilities. Benchmarking Tufts Health Plan inpatient payments to Medicare IPPS may yield volatile and potentially unreliable results due to a) differences in reimbursement methodology (Tufts Health Plan reimburses the majority of inpatient claims on either a Per Diem or Percent of Charge basis); b) our relatively small volume of business in Rhode Island; c) mix of services; and d) chargemaster levels to some of the hospitals in Rhode Island. Additionally, it is our belief that a Medicare comparison for some hospitals that perform very specific services, like Obstetrics, will not result in a comparison that is useful and may lead to unintended and/or misinterpreted conclusions.

Other Comments on Quality/Efficiency Incentives in Hospital Inpatient Contracting:

Part 2. Hospital Outpatient Services

- **Please fill out one row in the chart below for each general service institution (no specialty care, no rehab) with whom you contract in RI.**
- **Institution means hospital system if all contractual terms other than dollar amounts apply identically across all inpatient facilities in the contract.**
- **Outpatient Services include any services not involving an admission and covered under the contract with the institution.**

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[4]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - %of total payments for inpatient services in CY 2011 spent on quality incentive payments. [5]	__ Visit/Volume Reduction __ Others (please specify)	
2	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.5~1.0%____	__ Visit/Volume Reduction __ Others (please specify)	
3	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.1~0.5%	__ Visit/Volume Reduction __ Others (please specify)	
4	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality	__ Visit/Volume Reduction __ Others (please specify)	

[4] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[5] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[4]?	Utilization Incentives in Contract: (check all that apply)	Comments
		incentive payments. _____		
5	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
6	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
7	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
8	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	

Additional Questions for Hospital Outpatient Services

1. List the five most common areas of quality and service incentives in your company's hospital outpatient contracts:

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

(These measures apply to our hospital contracts that combine inpatient and outpatient services.)

i. Joint Commission measures (e.g., AMI, CHF, pneumonia)
ii. Leapfrog measures (e.g., CPOD, ICU staffing)
iii. Prevention of "Never Events"
iv. Surgical infection rates
v. Readmission rates

2. Percent of total payments to RI Hospitals for outpatient services in CY 2011 spent on quality incentive payments. 0.1~1%

3. Percent of total payments to RI Hospitals for outpatient services in CY 2011 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): n/a

4. Estimated Payments in first six months of CY 2011 for Outpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: 222% (i.e. 122% over Medicare Reimbursement) (add comments or caveats)

   For Outpatient Services, Tufts Health Plan has the technical capabilities to perform the required benchmarking analysis to Medicare; however, we have concerns about the confidence level in the accuracy of the supplied benchmark. Our concerns are due to a) the allowed reimbursement at a claim level was compared to fee information obtained from OPPS and CMS ancillary schedules such as Clinical Lab, DME etc.; b) we are not able to reprocess our claims through an OPPS Grouper and were limited to a line level reprice based on OPPS/Ancillary fees which means that exact Medicare reimbursement can only be approximated; c) Procedures that do not have a fee on OPPS/Ancillary schedules, or are billed in a different manner to Medicare (e.g., observation) were dropped from the analysis.

   Additionally, Tufts Health Plan has concerns that the results may be skewed due to a few high-volume hospitals and the large number of providers reimbursed on a percent of charges basis – factors that may distort the data due to particular mix of services and chargemaster levels of PAF providers. Based on the concerns listed above it is our belief that a Medicare comparison might not result in a benchmark that is useful and could lead to unintended and/or misinterpreted conclusions that if made public could impact certain contract negotiations by putting upward pressure on unit costs.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Other Comments on Quality/Efficiency Incentives in Hospital Outpatient Contracting:

Part 3: Professional Groups

- **"Professional Groups" is defined as non institutional/non facility groups with a valid contract and a single tax id number.**
- **Please provide information for the top 10 groups (measured by $ paid in 2011), filling in one row per group (10 rows in the table total).**

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	Multi-specialty	x Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [7] _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services _ Others (please specify)	
2	Multi-specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
3	Multi-specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code	No If yes - % of total payments for inpatient services in CY 2011 spent	__Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care	

[6] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[7] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
		__ Full/ Partial Capitation __Other (please specify)	on quality incentive payments. _____	__ use of pharmacy services __ Others (please specify)	
4	Sub - Specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
5	Primary Care	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
6	Primary Care	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0~5%	x Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care x use of pharmacy services x Others (please specify)	Quality/Member Satisfaction
7	Sub - Specialty	_ X _ Procedure-based methodology – using CPT, plan,	No	__ Visit/Volume Reduction __use of ancillary/referred services	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
		provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments.	__ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
8	Sub - Specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
9	Multi-specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
10	Multi-specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Additional Questions for Professional Groups

1. List the five most common areas of quality and service incentives in your company's professional group contracts:
   i. HEDIS (diabetes, breast cancer screening, colonoscopy, etc.)
   ii. HCHAPS
   iii. EMR adoption
   iv. Inpatient and ER use
   v. Rx Management
2. Percent of total payments to these ten professional groups in CY 2011 spent on quality incentive payments. ___<1%_____

3. Percent of total payments to these ten professional groups in CY 2011 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): ___n/a_____

4. Estimated Payments in first six months of CY 2011 for Professional Group Services as % of what Medicare would have paid for similar set. of services: 122% (i.e. 22% over Medicare Reimbursement) (add comments or caveats)

   The analysis was conducted using a claim line level comparison between allowed reimbursement and Medicare fee information obtained from RBRVS tables as well as Medicare ancillary schedules such as clinical lab, DME etc. Anesthesia services were also included. Procedures that Medicare does not reimburse but supplies RVU information for, such as preventive medicine and consults codes, are included at the RVU level rate for the Medicare comparison. Claims lines that do not have RBRVS/Ancillary schedule information were dropped from the analysis.

   Additionally, Tufts Health Plan has concerns that the results may be skewed due to particular mix of services for providers. Based on the concerns listed above it is our belief that a Medicare comparison might not result in a benchmark that is useful and could lead to unintended and/or misinterpreted conclusions that if made public could impact certain contract negotiations by putting upward pressure on unit costs.

Other Comments on Quality/Efficiency Incentives in Professional Group Contracting:

Selected Contract Sections Showing Compliance To OHIC Conditions

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Effective for dates of service on or after January 1, 2011

Office of the Health Insurance Commissioner Conditions

Pay-For-Performance: **[Redacted]** is available for the Hospital to earn based upon quality and/or efficiency measures **[redacted]**.

Case Rates: In the event **[redacted]** parties agree to meet to discuss the potential to transition to efficiency based payment methodologies (e.g., DRG, APC) in a manner that **[redacted]**.

Administrative Efficiency: Tufts Health Plan agrees to assign a Contract Specialist to provide ongoing contract related support through the term of the agreement to help mitigate contract related issues.

The Hospital agrees to work with and communicate issues to the Contract Specialist on an ongoing basis and work in good faith to resolve contract related issues in a timely manner.

Communication: During calendar year 2011 parties agree to formalize clinical communication that promotes and measures improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers.

Public Release of Contract Terms: Parties agree to allow the public release of terms outlined in this agreement if compelled by State regulatory authorities.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

1. Please provide an excel spreadsheet in the following format, detailing the 2011 actual and 2013 requested small and large group administrative costs pmpm, allocated among the NAIC- financial statement administrative cost categories. Please explain any significant changes from the financial filing for 2011 (increases/decreases of more than five percent in a particular category).

RI Insured HMO	2011 Actual (from filed financial statements)		2013 Proposed		% Change	
	Small Group	Large Group	Small Group	Large Group	Small Group	Large Group
Total Estimated Member Months	4,509	18,246	4,480	19,600	-0.6%	7.4%
Total Estimated Premiums ($pmpm)	$378.21	$397.92	$417.71	$439.41	10.4%	10.4%
Total General Administrative Expense	$41.82	$41.20	$43.68	$41.50	4.4%	0.7%
Total Cost Containment Expense	$10.43	$9.64	$10.10	$10.10	-3.2%	4.7%
Total Other Claim Adjustment Expense ($pmpm)	$7.99	$7.38	$7.73	$7.73	-3.2%	4.7%
Breakdown of General Administrative Expense ($pmpm)						
a. Payroll and benefits	$2.94	$2.72	$2.85	$2.85	-3.2%	4.7%
b. Outsourced Services (EDP, claims etc.)	$0.09	$0.09	$0.09	$0.09	-3.2%	4.7%
c. Auditing and consulting	$8.02	$7.42	$7.77	$7.77	-3.2%	4.7%
d. Commissions	$13.59	$14.62	$15.24	$13.06	12.1%	-10.6%
e. Marketing and Advertising	$1.76	$1.63	$1.71	$1.71	-3.2%	4.7%
f. Legal Expenses	$0.17	$0.16	$0.16	$0.16	-3.2%	4.7%
g. Taxes, Licenses and Fees	$7.56	$7.96	$8.83	$8.83	16.8%	11.0%
h. Reimbursements by Uninsured Plans	$0.00	$0.00	$0.00	$0.00	0.0%	0.0%
i. Other Admin Expenses	$7.68	$6.62	$7.04	$7.04	-8.4%	6.4%

Notes
1. The expense in any given administrative category may vary from year to year due to the small size of Tufts Health Plan's HMO block of business in Rhode Island. In aggregate, however, total admin has increased less than about 3% per year.

2. Please also provide an excel spreadsheet in the following format; detailing actual calendar year 2007-2011 fully insured commercial administrative costs, in accordance with the following table. This should be consistent with the annual statement filings to OHIC for administrative costs, providing additional detail on the components of administrative costs using the categories defined by NAIC financial statement and as allocated to commercially insured business only. Specifically, the information provided should agree with the "Exhibit of Premiums, Enrollment and Utilization" and the "Analysis of Operations by Line of Business" schedules included in the Annual Statements on file with OHIC. Where there are variance, a reconciliation and explanation should be provided.

Fully Insured Commercial Administrative Cost History

RI Insured HMO	2007	2008	2009	2010	2011
Total Premiums			1,212,134	6,544,977	8,965,746
Total General Administrative Expense			192,865	732,653	940,237
General Admin Exp. Ratio			15.9%	11.2%	10.5%
Total Fully Insured Member Months			3,878	18,547	22,755
General Administrative Expense ($pmpm)			$49.73	$39.50	$41.32
Breakdown of General Administrative Expense ($pmpm)					
a. Payroll and benefits			$3.37	$2.49	$2.76
b. Outsourced Services (EDP, claims etc.)			$0.01	$0.01	$0.09
c. Auditing and consulting			$5.92	$4.93	$7.54
d. Commissions			$11.74	$16.10	$14.41
e. Marketing and Advertising			$2.52	$1.72	$1.66
f. Legal Expenses			$0.08	$0.11	$0.16
g. Taxes, Licenses and Fees			$6.25	$7.06	$7.88
h. Reimbursements by Uninsured Plans			$0.00	$0.00	$0.00
i. Other Admin Expenses			$19.85	$7.03	$6.83
Cost Containment Expense			20,663	158,478	222,967
Other Claim Adjustment Expense			27,194	151,819	170,707
Total Self Insured Member Months for all Affiliated Companies doing business in RI			113,694	0	662

Notes:
1. Total premiums for 2010 differ from the aggregate amount submitted in last year's filing, but are consistent with the individual small and large group figures submitted last year.

RI Insured HMO

3. At the request of OHIC's Health Insurance Advisory Council, please provide brief answers to the following questions

- **In general and net of new taxes and fees, why should the rate of increase in Health Plan administrative costs exceed the general inflation rate?**

  Administrative expenses in total in a given year are adjusted for inflation, membership growth or loss and increases or decreases in corporate projects, which are often driven by regulatory requirements and government mandates. As a general practice, to set administrative expense targets for the annual financial plan, fixed administrative costs are grown at an inflationary rate. Variable administrative costs are then developed by applying inflation to the variable pmpm rate and then multiplying the inflated pmpm rate by planned member months. While those are the initial steps to develop targets, each administrative function is reviewed in detail to identify potential administrative cost savings and targets are adjusted accordingly.

- **What percentage of administrative costs does your organization consider fixed for the next five years? Provide detail by expense categories.**

  For the total company, we currently consider 58% of our costs fixed as follows:

Fixed Administrative Costs by Category:	
Network Management	2%
Sales and Marketing	4%
Clinical Services	5%
Operations	5%
IT & Business Effectiveness	8%
Corporate Projects	14%
Fixed Overhead and Other	20%
Total Fixed Administrative Expenses	58%

- **What administrative services are used by fully insured members that are not used by self-insured clients (e.g. broker commissions) and what are the estimated total costs ($pmpm) for those services?**

  Administrative costs for fully insured membership include expenses associated with medical cost containment ($9.80 pmpm), whereas in most cases self-insured clients bear these costs directly. Broker commissions ($14.41 pmpm) are also not applicable to most self-insured clients.

- **What does your plan use as its pmpm benchmarks or price points for commercial insurance administrative costs and why?**

We periodically participate in the benchmarking survey used to develop the *Sherlock Expense Evaluation Reports* (SEER) which are viewed as the definitive benchmarks for the functional areas of health plan administration. The Sherlock Expense Evaluation Reports (SEER) supply comprehensive and highly granular financial and operational metrics.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Health System Improvements Survey

The State of Rhode Island Office of the Health Insurance Commissioner Regulation 2 lists standards to be used by the Health Insurance Commissioner (Commissioner) for the assessment of the conduct of commercial health insurance issuers in Rhode Island for their efforts aimed at improving the efficiency and quality of health care delivery and increasing access to health care services. The standards include the following issuer activities:

1. Directing resources, including financial contributions, toward system-wide improvements in the state's health care system related to quality, access and efficiency, including providing support to local collaboratives, organizations, and initiatives that promote these three goals

2. Participating in the development and implementation of public policy issues related to health

To assist the Commissioner in this assessment, as part of the 2012 small and large employer group rate factor review process for commercial health insurance issuers in Rhode Island, please itemize and quantify your organization's contributions of finances and other material assets to these efforts in Rhode Island in calendar year 2011 in the following table.[1]

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
Funding	Grants provided by the Tufts Health Plan Foundation and Community Relations to the following RI organizations to support wellness and safety initiatives • **Best Buddies International** *Best Buddies Intergenerational College Project* Grant Amount: $20,000 • **Mount St. Rita Health Centre** *Blessings in a Back Pack* Grant Amount: $5,000 • **Bethany Home of Rhode Island Inc.**	**$515,724**

[1] The contributions can be to any entity other than a provider to improve medical and prevention services for all Rhode Islanders and to promote a coherent, integrated, and efficient statewide health care system.

State of Rhode Island Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920-4407
(401) 462-9640
(401) 462-9645 (Fax)
www.ohic.ri.gov

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
	Bethany Home Cares Grant Amount: $43,036 • **Homefront Health Care** *HIP-SAFE (Homefront Intervention to Prevent Slips & Falls in Elders)* Grant Amount: $59,438 • **Rhode Island Free Clinic Inc.** *Healthy Lifestyles for Today and Tomorrow* Grant Amount: $60,000 • **The Providence Center** *InShape Seniors* Grant Amount: $42,000 • **Ocean State Center for Independent Living (OSCIL)** *Home Sweet Accessible Home* Grant Amount: $40,000 • **Westbay Community Action Inc.** *Elder Safety* Grant Amount: $42,000 • **Rhode Island Quality Institute** *Health Information Exchange Support* Grant Amount: $25,000 • **EMR Payments** $179,250	

Participation in RI initiatives, programs and organizations	The goals of these programs, initiatives and organizations is to improve quality and/or transform primary care in the state:
	• CSI/Beacon (Project director, project manager, and nurse case manager support) $38,329
	• Value of Resource Time in Various Programs (Estimate of $30,000 for 0.2 FTE for 2011)
	  ○ RI DOH Medical Director meetings
	  ○ RI Quality Partners Safe Transitions
	  ○ RI Senate Commission on Hospital Payment Reform
	  ○ RIQI Board of Directors
	  ○ RI CSI Beacon Executive Committee
		$68,329

Thank you for your cooperation.

Tufts Insurance Company

Small Group Rate Filing -- Effective Date January 1, 2013

Part 1. Historical Information

Experience Period for Developing Rates	
From	**To**
01/01/2009	12/31/2011

Utilization/Experience Data by Quarter (Last 12 Available Quarters)

Quarter	End Date	IP Days	Member Months	Earned Premium	Incurred Claims Total	Incurred Claims IP	Incurred Claims OP	Incurred Claims Primary Care	Incurred Claims Other M/S	Incurred Claims Rx	Loss Ratio	Quality Improvement Expense*	Other Cost Containment Expense*	Other Claim Adjustment Expense*	Other Operating Expense*	Investment Income Credit	Commissions	Contribution to Reserves
1 (Oldest)	03/31/2009	76	1,102	$405,221	$701,562	$468,348	$61,421	$23,191	$111,445	$37,158	175.4%	$9,009	$4,958	$6,486	$37,439	N/A	$23,873	($378,107)
2	06/30/2009	132	3,007	$1,042,273	$1,331,406	$573,675	$187,236	$57,272	$406,296	$106,926	130.1%	$24,583	$13,529	$17,698	$102,160	N/A	$65,141	($512,244)
3	09/30/2009	36	3,800	$1,293,844	$959,092	$138,405	$306,968	$78,223	$302,586	$132,911	76.5%	$31,066	$17,096	$22,365	$129,101	N/A	$82,319	$52,803
4	12/31/2009	139	4,217	$1,447,488	$1,190,529	$296,776	$260,194	$86,067	$392,450	$155,042	84.7%	$34,917	$19,215	$25,137	$144,679	N/A	$92,523	($59,511)
5	03/31/2010	21	3,760	$1,268,976	$849,611	$81,861	$247,686	$75,560	$304,262	$140,242	69.3%	$29,734	$14,111	$18,460	$104,600	N/A	$74,460	$177,999
6	06/30/2010	28	2,719	$939,442	$760,321	$179,215	$171,752	$60,517	$242,771	$106,065	83.2%	$21,554	$10,229	$13,382	$75,765	N/A	$53,974	$4,217
7	09/30/2010	17	2,411	$860,083	$608,511	$54,219	$183,883	$57,653	$220,731	$92,024	73.0%	$19,020	$9,027	$11,808	$66,961	N/A	$47,629	$97,127
8	12/31/2010	48	2,255	$824,757	$770,902	$162,112	$182,154	$57,529	$247,289	$121,818	95.6%	$17,823	$8,459	$11,066	$62,710	N/A	$44,633	($90,836)
9	03/31/2011	49	1,940	$720,955	$798,139	$190,611	$203,824	$50,202	$243,663	$109,840	112.6%	$13,829	$8,688	$10,627	$51,199	N/A	$26,167	($187,695)
10	06/30/2011	13	1,781	$671,036	$426,035	$25,535	$112,155	$39,990	$161,042	$87,312	65.4%	$12,695	$7,976	$9,756	$47,003	N/A	$24,022	$143,548
11	09/30/2011	63	1,540	$604,262	$658,934	$178,642	$175,090	$35,358	$190,531	$79,314	110.9%	$10,977	$6,896	$8,436	$40,643	N/A	$20,772	($142,397)
12	12/31/2011	42	1,433	$573,713	$402,302	$21,777	$111,229	$37,188	$161,666	$70,442	71.9%	$10,215	$6,417	$7,850	$37,819	N/A	$19,329	$89,781

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3- Analysis of Expenses and/or to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1
If any of the historical information reported is different from that period as reported in the prior rate filing, please provide a reconciliation and explanation showing the amount of each element of difference.

Notes:
1. The Other Operating Expenses shown above include taxes, licenses and fees, which were excluded in previous filings for the same time periods
2. Primary care claims definition has been revised to match the Primary Care Spend report
3. Expenses such as network access fee, COB and claims interest are moved from Other M/S claims to administrative expenses according to NAIC definition
4. Claims Total differences from the previous filings for the same time periods are due to updated IBNR factors that reflect more up to date claims payment, as well as the revision to the Other M/S claims definition
5. Loss ratio is calculated as (Incurred Claims Total + Quality Improvement Expense) / Earned Premium

Part 2. Prospective Information

A. 2013 Trend Factors for Projection Purposes (Annualized)

	IP	OP	Primary Care	Other M/S	Rx	Weighted Total
Total	5.2%	6.7%	5.4%	4.7%	4.7%	5.4%
Price Only	3.6%	3.4%	3.3%	1.8%	0.8%	2.6%
Utilization	1.5%	3.2%	2.0%	2.9%	3.9%	2.8%
Other**						
Other**						
Other**						
Weights	20.4%	26.5%	9.4%	26.3%	17.4%	**100%**

** All elements should add or compound to the total. If anything is to be reported as "Other" please provide a description.

2012 Trend Factors for Projection Purposes (Annualized)

	IP	OP	Primary Care	Other M/S	Autism Mandate	Rx	Weighted Total
Total	5.9%	7.6%	6.4%	4.8%	0.2%	0.3%	5.3%
Price Only	3.6%	3.7%	4.1%	1.3%		-3.6%	1.9%
Utilization	2.2%	3.8%	2.2%	3.5%		4.0%	3.3%
Other**							
Other**							
Other**							
Weights	20.2%	24.7%	8.4%	29.3%		17.4%	**100%**

** All elements should add or compound to the total. If anything is to be reported as "Other" please provide a description.

B. The following items for the period to which the rate filing applies, by quarter:

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %
1	01/01/2013	6.8%	85.2%	0.0%	1.6%	1.1%	1.4%	4.5%	3.2%	0.0%	3.0%
2	04/01/2013	6.5%	85.2%	0.0%	1.6%	1.1%	1.4%	4.5%	3.2%	0.0%	3.0%
3	07/01/2013	6.6%	85.2%	0.0%	1.6%	1.1%	1.4%	4.5%	3.2%	0.0%	3.0%
4	10/01/2013	6.8%	85.2%	0.0%	1.6%	1.1%	1.4%	4.5%	3.2%	0.0%	3.0%
Weighted Average		6.7%	85.2%	0.0%	1.6%	1.1%	1.4%	4.5%	3.2%	0.0%	3.0%

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %
1	01/01/2012	3.4%	86.5%	0.0%	1.1%	0.8%	1.1%	5.0%	3.2%	0.0%	2.3%
2	04/01/2012	3.0%	86.5%	0.0%	1.1%	0.8%	1.1%	5.0%	3.2%	0.0%	2.3%
3	07/01/2012	4.0%	86.5%	0.0%	1.1%	0.8%	1.1%	5.0%	3.2%	0.0%	2.3%
4	10/01/2012	6.6%	86.5%	0.0%	1.1%	0.8%	1.1%	5.0%	3.2%	0.0%	2.3%
Weighted Average		4.2%	86.5%	0.0%	1.1%	0.8%	1.1%	5.0%	3.2%	0.0%	2.3%

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3 - Analysis of Expenses and to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1
The sum of the expenses, commissions, contributions to reserves, investment income credit, taxes and the medical loss ratio should be 100%.

C. Average Rate Increase Components

The following items should reconcile to the Weighted Average Percent Rate Increase for the year:

	Price	Utilization, Mix	Total
Hospital Inpatient Price	0.6%	0.3%	0.9%
Hospital Outpatient	0.8%	0.7%	1.5%
Primary Care	0.3%	0.2%	0.4%
Med/Surg Other Than Primary Care	0.4%	0.6%	1.0%
Pharmacy	0.1%	0.6%	0.7%
Administrative Expense (Aggregated)			0.6%
Contribution to Reserves			0.0%
Taxes and Assessments			0.9%
Legally Mandated Changes			0.0%
Prior Period Adjustment (+/-)			0.6%
Total			6.7%

Note:
1. Due to the lack of credible experience, manual rates are developed by trending forward prior base rates to reflect trend changes. Therefore, depending on the timing of trend change, rate increases may be different from trend increase. The difference is reflected as Prior Period Adjustment above.

Part 3. Retrospective Reconciliation of Experience with Filed Factors

	Filed Data[1]					PMPM Increase[2]		Standard Plan PMPM[3]		Standard Plan Increase[4]		Approved		Loss Ratio	
Year	Member Months	Earned Premium	Incurred Claims Total	Premium PMPM	Claims PMPM	Premium	Claims	Premium	Claims	Premium	Claims	Trend Increase%	Contrib to Reserves%	Actual%	Filed%
2009	12,126	4,188,825	4,282,166	$345.44	$353.14			376.24	576.75			9.7%	0%	102.2%	87.0%
2010	11,145	3,893,259	3,077,477	$349.33	$276.13	1.1%	-21.8%	354.15	284.33	-5.9%	-50.7%	9.5%	0%	79.0%	87.0%
2011	6,694	2,569,965	2,333,127	$383.92	$348.54	9.9%	26.2%	327.93	784.15	-7.4%	175.8%	9.2%	0%	90.8%	87.6%

[1] Corresponds to historical Information data in Part 1 above
[2] Percent increase compared to prior year
[3] For most commonly held plan of benefits in 2010 and for the same plan of benefits in 2011
[4] Percent increase compared to prior year

Note:
1. Filed loss ratio for CY 2011 is the sum of the expected pure medical cost ratio and expected quality improvement expenses % in 2011 rate factor filing

Rhode Island Health Statement Supplement

Cover Sheet

Company Name	**Tufts Associated Health Maintenance Organizations & Tufts Insurance Company**		
Enter NAIC#	**95688 & 60177**	**Reporting Year**	**2011**
Enter DBR registration # (TPAs)			

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Office of the Health Insurance Commissioner
1511 Pontiac Ave, Building #69 first floor
Cranston, RI 02920
(401) 462-9517
(401) 462-9645 (fax)
HealthInsInquiry@ohic.ri.gov

Line of Business Exhibit

Field			1 Comprehensive/Major medical			2 ASO/TPA			3 Stop loss/ Excess loss/Reinsurance			4 Medicare Part C			5 Medicare Part D			6 Medicare Supplement Policies			7 Medicaid/Other public			8 Student blanket			9 Dental Only			10 Other Medical Non-Comprehensive			11 Total (Across all lines of business)		
			RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
1		**Membership Data**																																
		Number of Polices or Certificates	197	-	197	1	-	1			-			-	91		91	3	-	3			-			-			-			-	292	-	292
		Number of Covered Lives	3,936	737	4,673	299	29	328			-			-	91		91	5	-	5			-			-			-			-	4,331	766	5,097
		Member Months	48,618	8,909	57,527	603	59	662			-			-	1,062		1,062	60	-	60			-			-			-			-	50,343	8,968	59,311
		Number of Polices or Certificates (**Plans with PD benefits**)	197	-	197	1	-	1	-	-	-	-	-	-	91	-	91	3	-	3	-	-	-	-	-	-	-	-	-	-	-	-	292	-	292
		Number of Covered Lives (**Plans with PD benefits**)	3,936	737	4,673	299	29	328	-	-	-	-	-	-	91	-	91	5	-	5	-	-	-	-	-	-	-	-	-	-	-	-	4,331	766	5,097
		Member Months (**Plans with PD benefits**)	48,618	8,909	57,527	603	59	662	-	-	-	-	-	-	1,062	-	1,062	60	-	60	-	-	-	-	-	-	-	-	-	-	-	-	50,343	8,968	59,311
2		**Premiums/Claims**																																
		Premium	19,382,569	3,553,785	22,936,354	162,614	18,088	180,702			-			-	146,221		146,221	23,160	-	23,160			-			-			-			-	19,714,564	3,571,873	23,286,437
		Claims/Medical Expenses	17,496,249	3,228,233	20,724,482	139,151	15,072	154,222			-			-	405,690		405,690	20,052	-	20,052			-			-			-			-	18,061,142	3,243,305	21,304,446
3		**Inpatient Facility**																																
		Hospital																																
	1	In-state	3,158,748	206,043	3,364,791	17,550	-	17,550			-			-			-	-	-	-			-			-			-			-	3,176,298	206,043	3,382,341
	2	Out-of-state	540,726	359,998	900,724	-	-	-			-			-			-	-	-	-			-			-			-			-	540,726	359,998	900,724
	3	Total (Lines 1 + 2)	3,699,474	566,041	4,265,515	17,550	-	17,550	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3,717,024	566,041	4,283,065
		SNF																																
	4	In-state	33,154	5,624	38,778	-	-	-			-			-			-	-	-	-			-			-			-			-	33,154	5,624	38,778
	5	Out-of-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	6	Total (Lines 4 + 5)	33,154	5,624	38,778	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	33,154	5,624	38,778
		Other																																
	7	In-state	1,167	-	1,167	-	-	-			-			-			-	-	-	-			-			-			-			-	1,167	-	1,167
	8	Out-of-state	-	12,761	12,761	-	-	-			-			-			-	-	-	-			-			-			-			-	-	12,761	12,761
	9	Total (Lines 7 + 8)	1,167	12,761	13,928	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,167	12,761	13,928
	10	**Total Inpatient Facility (Lines 3 + 6 + 9)**	3,733,795	584,427	4,318,222	17,550	-	17,550	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3,751,345	584,427	4,335,772
4		**Outpatient Facility**																																
		Hospital																																
	11	In-state	3,352,396	210,704	3,563,100	22,675	916	23,591			-			-			-	1,633	-	1,633			-			-			-			-	3,376,704	211,620	3,588,324
	12	Out-of-state	317,396	538,951	856,347	1,088	1,834	2,922			-			-			-	-	-	-			-			-			-			-	318,484	540,785	859,269
	13	Total (Lines 11 + 12)	3,669,791	749,655	4,419,447	23,763	2,749	26,512	-	-	-	-	-	-	-	-	-	1,633	-	1,633	-	-	-	-	-	-	-	-	-	-	-	-	3,695,188	752,404	4,447,593
		SNF																																
	14	In-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	15	Out-of-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	16	Total (Lines 14 + 15)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
		Freestanding Ambulatory Care Facility																																
	17	In-state	747,250	53,967	801,218	1,893	-	1,893			-			-			-	-	-	-			-			-			-			-	749,143	53,967	803,110
	18	Out-of-state	168,850	101,890	270,740	-	4,631	4,631			-			-			-	-	-	-			-			-			-			-	168,850	106,521	275,371
	19	Total (Lines 17 +18)	916,100	155,858	1,071,958	1,893	4,631	6,524	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	917,993	160,489	1,078,482
		Other																																
	20	In-state	728,426	17,731	746,156	2,074	115	2,189			-			-			-	310	-	310			-			-			-			-	730,809	17,845	748,655
	21	Out-of-state	146,342	140,799	287,140	945	369	1,314			-			-			-	47	-	47			-			-			-			-	147,334	141,167	288,501
	22	Total (Lines 20 + 21)	874,767	158,529	1,033,296	3,019	484	3,503	-	-	-	-	-	-	-	-	-	357	-	357	-	-	-	-	-	-	-	-	-	-	-	-	878,143	159,013	1,037,156
	23	**Total Outpatient Facility (Lines 13 + 16 + 19 + 22)**	5,460,659	1,064,042	6,524,701	28,676	7,864	36,539	-	-	-	-	-	-	-	-	-	1,990	-	1,990	-	-	-	-	-	-	-	-	-	-	-	-	5,491,325	1,071,906	6,563,231
5		**Primary Care**																																
	24	**Total Primary Care**	1,115,436	219,726	1,335,162	15,201	842	16,043			-			-			-	679	-	679			-			-			-			-	1,131,316	220,567	1,351,883
6		**Pharmacy**																																
	25	**Total Pharmacy**	3,060,587	545,750	3,606,337	44,737	1,491	46,227			-			-	405,690		405,690	10,316	-	10,316			-			-			-			-	3,521,330	547,241	4,068,570
7		**Medical/Surgical other than primary care**																																
	26	In-state	2,373,477	133,824	2,507,301	17,385	1,341	18,726			-			-			-	5,354	-	5,354			-			-			-			-	2,396,216	135,165	2,531,381
	27	Out-of-state	429,183	432,394	861,577	442	1,815	2,257			-			-			-	-	-	-			-			-			-			-	429,625	434,208	863,834
	28	**Total Other Medical/Surgical (Lines 26 + 27)**	2,802,660	566,218	3,368,878	17,828	3,155	20,983	-	-	-	-	-	-	-	-	-	5,354	-	5,354	-	-	-	-	-	-	-	-	-	-	-	-	2,825,841	569,374	3,395,215
8		**All other payments to medical providers**																																
	29	**Total**	1,323,112	248,070	1,571,182	15,159	1,720	16,880			-			-			-	1,714	-	1,714			-			-			-			-	1,339,986	249,790	1,589,776

Field	Market Exhibit (For Comprehensive/Major Medical Line of Business)	1 Individual			2 Small Group			3 Large Group			4 Association			5 Trust			6 Federal Employee Health Benefit Plan			7 Other Health Market			8 Total (Across all markets)		
		RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
	Membership Data																								
	Number of Polices or Certificates	1	-	1	165	-	165	31	-	31			-			-			-			-	197	-	197
	Number of Covered Lives	1	-	1	702	140	842	3,233	597	3,830			-			-			-			-	3,936	737	4,673
1	Member Months	12	-	12	9,473	1,838	11,311	39,133	7,071	46,204			-			-			-			-	48,618	8,909	57,527
	Number of Polices or Certificates (**Plans with PD benefits**)	1	-	1	165	-	165	31	-	31	-	-	-	-	-	-	-	-	-	-	-	-	197	-	197
	Number of Covered Lives (**Plans with PD benefits**)	1	-	1	702	140	842	3,233	597	3,830	-	-	-	-	-	-	-	-	-	-	-	-	3,936	737	4,673
	Member Months (**Plans with PD benefits**)	12	-	12	9,473	1,838	11,311	39,133	7,071	46,204	-	-	-	-	-	-	-	-	-	-	-	-	48,618	8,909	57,527
	Premiums/Claims																								
2	Premium	2,874	-	2,874	3,658,257	690,328	4,348,585	15,721,439	2,863,457	18,584,896			-			-			-			-	19,382,569	3,553,785	22,936,354
	Claims/Medical Expenses	1,660	-	1,660	3,100,638	454,637	3,555,275	14,393,951	2,773,596	17,167,547			-			-			-			-	17,496,249	3,228,233	20,724,482
	Inpatient Facility																								
	Hospital																								
1	In-state	-	-	-	441,217	49,217	490,434	2,717,530	156,826	2,874,356			-			-			-			-	3,158,748	206,043	3,364,791
2	Out-of-state	-	-	-	52,816	12,154	64,969	487,911	347,844	835,755			-			-			-			-	540,726	359,998	900,724
3	Total (Lines 1 + 2)	-	-	-	494,033	61,371	555,404	3,205,441	504,670	3,710,111	-	-	-	-	-	-	-	-	-	-	-	-	3,699,474	566,041	4,265,515
	SNF																								
3 4	In-state	-	-	-	7,542	-	7,542	25,612	5,624	31,236			-			-			-			-	33,154	5,624	38,778
5	Out-of-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
6	Total (Lines 4 + 5)	-	-	-	7,542	-	7,542	25,612	5,624	31,236	-	-	-	-	-	-	-	-	-	-	-	-	33,154	5,624	38,778
	Other																								
7	In-state	-	-	-	-	-	-	1,167	-	1,167			-			-			-			-	1,167	-	1,167
8	Out-of-state	-	-	-	-	-	-	-	12,761	12,761			-			-			-			-	-	12,761	12,761
9	Total (Lines 7 + 8)	-	-	-	-	-	-	1,167	12,761	13,928	-	-	-	-	-	-	-	-	-	-	-	-	1,167	12,761	13,928
10	**Total Inpatient Facility (Lines 3 + 6 + 9)**	-	-	-	501,575	61,371	562,946	3,232,220	523,056	3,755,276	-	-	-	-	-	-	-	-	-	-	-	-	3,733,795	584,427	4,318,222
	Outpatient Facility																								
	Hospital																								
11	In-state	-	-	-	514,964	32,443	547,407	2,837,431	178,261	3,015,692			-			-			-			-	3,352,396	210,704	3,563,100
12	Out-of-state	-	-	-	117,047	54,151	171,198	200,349	484,800	685,149			-			-			-			-	317,396	538,951	856,347
13	Total (Lines 11 + 12)	-	-	-	632,011	86,594	718,605	3,037,780	663,061	3,700,842	-	-	-	-	-	-	-	-	-	-	-	-	3,669,791	749,655	4,419,447
	SNF																								
14	In-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
15	Out-of-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
4 16	Total (Lines 14 + 15)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Freestanding Ambulatory Care Facility																								
17	In-state	-	-	-	160,253	5,262	165,515	586,997	48,705	635,702			-			-			-			-	747,250	53,967	801,218
18	Out-of-state	-	-	-	42,588	11,594	54,182	126,262	90,297	216,558			-			-			-			-	168,850	101,890	270,740
19	Total (Lines 17 + 18)	-	-	-	202,841	16,856	219,698	713,259	139,002	852,260	-	-	-	-	-	-	-	-	-	-	-	-	916,100	155,858	1,071,958
	Other																								
20	In-state	1,420	-	1,420	109,081	7,179	116,260	617,925	10,551	628,476			-			-			-			-	728,426	17,731	746,156
21	Out-of-state	-	-	-	15,956	30,833	46,788	130,386	109,966	240,352			-			-			-			-	146,342	140,799	287,140
22	Total (Lines 20 + 21)	1,420	-	1,420	125,037	38,012	163,048	748,311	120,517	868,828	-	-	-	-	-	-	-	-	-	-	-	-	874,767	158,529	1,033,296
23	**Total Outpatient Facility (Lines 13 + 16 + 19 + 22)**	1,420	-	1,420	959,889	141,462	1,101,351	4,499,350	922,580	5,421,930	-	-	-	-	-	-	-	-	-	-	-	-	5,460,659	1,064,042	6,524,701

5		**Primary Care**																							
	24	**Total Primary Care**	-	-	-	236,566	66,277	302,843	878,870	153,449	1,032,319			-			-			-			-	1,115,436	219,726	1,335,162
6		**Pharmacy**																							
	25	**Total Pharmacy**			-	560,457	63,013	623,470	2,500,130	482,738	2,982,868			-			-			-			-	3,060,587	545,750	3,606,337
7		**Medical/Surgical other than primary care**																							
	26	In-state	107	-	107	500,447	25,883	526,330	1,872,922	107,942	1,980,864			-			-			-			-	2,373,477	133,824	2,507,301
	27	Out-of-state	-	-	-	100,752	54,851	155,604	328,431	377,542	705,973			-			-			-			-	429,183	432,394	861,577
	28	**Total Other Medical/Surgical (Lines 26 + 27)**	107	-	107	601,200	80,734	681,934	2,201,353	485,484	2,686,837	-	-	-	-	-	-	-	-	-	-	-	-	2,802,660	566,218	3,368,878
8		**All other payments to medical providers**																							
	29	**Total**	133	-	133	240,951	41,780	282,732	1,082,028	206,290	1,288,317			-			-			-			-	1,323,112	248,070	1,571,182

2012 Rate Review Process
Areas of Medical Expense Variation

Introductory Remarks

The stated goal of this exercise is to improve OHIC's understanding of the drivers of rising medical spending in Rhode Island by comparing the experience of the issuer's Rhode Island member base to a benchmark. For the purposes of this analysis, we have used our 2011 fully insured MA HMO experience as the benchmark. However, given the size of Tufts Health Plan's membership base in Rhode Island, the results of this comparative analysis will have limited credibility. Our relative costs by area of care have changed significantly in Rhode Island from year to year and are expected to continue to be volatile as our population in this market grows. Although we have commented on the probable causes of each variation listed, these fundamentally reflect a small, immature market compared to a much larger, more mature benchmark and should be interpreted with caution.

1. The top five areas of care, based on *per capita total dollar value* positive variation from the benchmark

Area of Care	Total Excess Spending	PMPM Excess Spending	Comments on Estimated Cause
INPATIENT ACUTE MED/SURG	$1,339,638	$23.29	Attributable to higher utilization (both admits and ALOS), rather than unit cost. High cost claimants identified as having a disproportionately large impact. The higher number of admits may be a consequence of lower than benchmark outpatient professional care.
PHARMACY - Rx MM	$717,042	$12.46	Attributable to higher utilization across tiers and therapeutic classes. Higher utilization driven by more members in RI having prescriptions filled than in the benchmark population, rather than a higher number of prescriptions per member.
OUTPATIENT LABORATORY	$558,538	$9.71	Capitation strategy applied in the benchmark population successfully contains cost.
OUTPATIENT INJECTIONS	$425,609	$7.40	Driven primarily by a difference in payment methodology between RI and the benchmark population. Injection claims in RI are reimbursed on a fee for service basis while in the benchmark population they are reimbursed on a fee for service basis or bundled into an outpatient surgery case payment. More than 50% of the higher RI utilization is associated with outpatient surgery claims, which would not be separately identified in the benchmark population.
OUTPATIENT EMERGENCY ROOM	$406,508	$7.07	Attributable primarily to a higher cost per emergency room encounter. This higher cost per encounter is driven less by higher unit cost in RI and more by the higher number of services delivered within an emergency room encounter compared to the benchmark.

2. The top five areas of care, based on *the percent of positive variation in per capita spending* from the benchmark

Area of Care	Percent of Positive Variation	Total Excess Spending	Comments on Estimated Cause
OUTPATIENT INJECTIONS	158%	$425,609	Driven primarily by a difference in payment methodology as described above.
FREE STANDING HIGH COST RADIOLOGY (MRI, PET, CT)	124%	$130,764	Higher utilization of allied health facilities, along with lower Outpatient Hospital High Cost Radiology utilization, reflects appropriate re-direction of care to lower cost providers.
OUTPATIENT LABORATORY	96%	$558,538	Capitation strategy applied in the benchmark population successfully contains cost.
INPATIENT OTHER	74%	$117,886	Driven by Mental Health/Substance Abuse services. Capitation strategy for inpatient Mental Health/Substance Abuse within the benchmark population effective at containing costs.
OUTPATIENT EMERGENCY ROOM	63%	$406,508	Attributable primarily to the number of services delivered within an emergency room encounter, as described above.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Provider Contracting Practices and Hospital Contracting Conditions Verification Questionnaire

Background

The Health Insurance Advisory Council (HIAC) to the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) has promulgated Affordability Standards for commercial health insurance issuers in Rhode Island.

Health plans will improve the affordability of health care in Rhode Island by focusing their efforts upon provider payment reform, beginning with primary care. Achievement of this goal will not add to overall medical spend in the short-term, and is expected to produce savings thereafter. Specific areas of focus in support of this goal are as follows:

1. Expand and improve the primary care infrastructure in the state—with limitations on ability to pass on cost in premiums
2. Spread Adoption of the "Chronic Care Model" Medical Home
3. Standardize electronic medical record (EMR) incentives
4. Work toward comprehensive payment reform across the delivery system

To support standard four, OHIC has previously issued six conditions for issuer contracts with hospitals in Rhode Island, to be implemented by issuers upon contract execution, renewal, or extension. These are as follows:

1. Utilize unit of service payment methodologies for both inpatient and hospital outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee for service.
2. Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index ("Index"), for all contractual and optional years covered by the contract
3. Provide the opportunity for hospitals to increase their total annual revenue for

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

commercially insured enrollment under the contract by at least additional two percentage points over the previous contract year by improving or attaining mutually agreed-to performance levels for no less than three nationally-accepted clinical quality, service quality or efficiency-based measures.

4. Include terms that define the parties' mutual obligations for greater administrative efficiencies
5. Include terms that promote and measure improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers.
6. Include terms that explicitly relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement.

The purpose of this questionnaire is to assess compliance with standard four of the Affordability Standards and to consider the responses in connection with OHIC's 2012 small and large employer group rate factor review process for commercial health insurance issuers in Rhode Island.

Directions

1. Please fill out all parts of questionnaire.
2. As no providers are identified and no financial details are solicited, none of this information will be considered proprietary or confidential. Should any information or document be considered confidential by the filer, the filer must request approval of the Health Insurance Commissioner. The request must identify the specific information or document (or portion thereof) which the filer considers confidential, accompanied by a factual and legal analysis supporting the request.
3. Questionnaire responses must be verified by filing those portions of each hospital contract which support the survey response. An index or other method of reference must be included to identify which hospital contract documentation relates to each survey response. Any contract excerpts provided will be summarized for review.
4. Please contact OHIC with any questions.

State of Rhode Island Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920-4407
(401) 462-9640
(401) 462-9645 (Fax)
www.ohic.ri.gov
THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

General comment:

Tufts Health Plan has a long standing commitment to investment in payer-provider incentive alignment, and we maintain hospital and physician incentive programs that apply to the vast majority of our network providers. As a relatively new entrant into the RI market, we are at an early stage of incorporating incentive mechanisms into our RI provider contracts. Provider incentive will be a key component of our contracting strategy as we grow our presence in the state of RI.

Tufts Health Plan requests that the information provided in response to this survey be deemed to constitute "trade secrets" within the meaning of the term in section 38-2-2(4)(i)(B) of the Rhode Island General Laws. We have included a footer stating "THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION".

Finally, due to the questionable reliability of certain information provided in our responses, which is explained in further detail below, it is Tufts Health Plan's expectation and understanding that the information provided in this Provider Survey will not be used or considered in OHIC's review of Tufts Health Plan's rates.

Part 1. Hospital Inpatient Services

- **Please fill out one row in the chart below for <u>each</u> general service institution (no specialty care, no rehab) with whom you contract in RI.**
- **Institution means hospital system if all contractual terms other than $ amounts apply identically across all inpatient facilities in the contract.**
- **Incentives refer to activities or measures resulting in additional payments by the insurer.**

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments

[1] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[2] Attach analysis and relevant documentation from contracts to demonstrate compliance status.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
1	3 Years	X DRG X Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	No	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [3]	__ admission reductions __ day reductions __ process/structural changes (e.g. discharge practices) __Others (please specify)	N/A (Contract has not been renegotiated)	
2	3 Years	x DRG x Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.5~1.0%____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
3	3 Years	__DRG __Per Diem x % of Charges __ Bundled Services	No	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

[3] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
		__ Capitation or other budgeting __Others (please specify)		incentive payments. 0.1~0.5%			
4	2 Years	__DRG x Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
5	3 Years	__DRG __Per Diem x % of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	No	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
6	3 Years	__DRG __Per Diem x % of Charges __ Bundled	No	No If yes - % of total payments for inpatient services in CY	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
		Services __ Capitation or other budgeting __Others (please specify)		2011 spent on quality incentive payments. _____			
7	1 Year	__DRG _x_Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. ____ 0-2%	_X_ admission reductions _X_ day reductions __Others (please specify)	Yes, please see attached	
8	3 Years	__DRG _x_Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

Additional Questions for Hospital Inpatient Services

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

1. List the five most common areas of quality and service incentives in your company's inpatient contracts:
(These measures apply to our hospital contracts that combine inpatient and outpatient services.)
   i. Joint Commission measures (e.g., AMI, CHF, pneumonia)
   ii. Leapfrog measures (e.g., CPOD, ICU staffing)
   iii. Prevention of "Never Events"
   iv. Surgical infection rates
   v. Readmission rates
2. Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2011 spent on quality incentive payments. 0.1~1%

3. Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2011 paid through units of service based on efficient resource use (i.e DRG, Capitation, Bundled Service or partial/global budgeting): <5%

4. Estimated Payments in first six months of CY 2011 for Inpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: See comment (add comments or caveats)

   For inpatient services Tufts Health Plan does not currently have the technical capability to benchmark to Medicare IPPS reimbursement. Conducting such analysis would require incremental time, resources and technical capabilities. Benchmarking Tufts Health Plan inpatient payments to Medicare IPPS may yield volatile and potentially unreliable results due to a) differences in reimbursement methodology (Tufts Health Plan reimburses the majority of inpatient claims on either a Per Diem or Percent of Charge basis); b) our relatively small volume of business in Rhode Island; c) mix of services; and d) chargemaster levels to some of the hospitals in Rhode Island. Additionally, it is our belief that a Medicare comparison for some hospitals that perform very specific services, like Obstetrics, will not result in a comparison that is useful and may lead to unintended and/or misinterpreted conclusions.

Other Comments on Quality/Efficiency Incentives in Hospital Inpatient Contracting:

Part 2. Hospital Outpatient Services

- **Please fill out one row in the chart below for each general service institution (no specialty care, no rehab) with whom you contract in RI.**
- **Institution means hospital system if all contractual terms other than dollar amounts apply identically across all inpatient facilities in the contract.**
- **Outpatient Services include any services not involving an admission and covered under the contract with the institution.**

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[4]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - %of total payments for inpatient services in CY 2011 spent on quality incentive payments. [5]	__ Visit/Volume Reduction __ Others (please specify)	
2	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.5~1.0%____	__ Visit/Volume Reduction __ Others (please specify)	
3	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.1~0.5%	__ Visit/Volume Reduction __ Others (please specify)	
4	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality	__ Visit/Volume Reduction __ Others (please specify)	

[4] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[5] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[4]?	Utilization Incentives in Contract: (check all that apply)	Comments
		incentive payments. _____		
5	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
6	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
7	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
8	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	

Additional Questions for Hospital Outpatient Services

1. List the five most common areas of quality and service incentives in your company's hospital outpatient contracts:

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

(These measures apply to our hospital contracts that combine inpatient and outpatient services.)

i. Joint Commission measures (e.g., AMI, CHF, pneumonia)
ii. Leapfrog measures (e.g., CPOD, ICU staffing)
iii. Prevention of "Never Events"
iv. Surgical infection rates
v. Readmission rates

2. Percent of total payments to RI Hospitals for outpatient services in CY 2011 spent on quality incentive payments. 0.1~1%

3. Percent of total payments to RI Hospitals for outpatient services in CY 2011 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): n/a

4. Estimated Payments in first six months of CY 2011 for Outpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: 222% (i.e. 122% over Medicare Reimbursement) (add comments or caveats)

   For Outpatient Services, Tufts Health Plan has the technical capabilities to perform the required benchmarking analysis to Medicare; however, we have concerns about the confidence level in the accuracy of the supplied benchmark. Our concerns are due to a) the allowed reimbursement at a claim level was compared to fee information obtained from OPPS and CMS ancillary schedules such as Clinical Lab, DME etc.; b) we are not able to reprocess our claims through an OPPS Grouper and were limited to a line level reprice based on OPPS/Ancillary fees which means that exact Medicare reimbursement can only be approximated; c) Procedures that do not have a fee on OPPS/Ancillary schedules, or are billed in a different manner to Medicare (e.g., observation) were dropped from the analysis.

   Additionally, Tufts Health Plan has concerns that the results may be skewed due to a few high-volume hospitals and the large number of providers reimbursed on a percent of charges basis – factors that may distort the data due to particular mix of services and chargemaster levels of PAF providers. Based on the concerns listed above it is our belief that a Medicare comparison might not result in a benchmark that is useful and could lead to unintended and/or misinterpreted conclusions that if made public could impact certain contract negotiations by putting upward pressure on unit costs.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Other Comments on Quality/Efficiency Incentives in Hospital Outpatient Contracting:

Part 3: Professional Groups

- **"Professional Groups" is defined as non institutional/non facility groups with a valid contract and a single tax id number.**
- **Please provide information for the top 10 groups (measured by $ paid in 2011), filling in one row per group (10 rows in the table total).**

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	Multi-specialty	x Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [7] _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services _ Others (please specify)	
2	Multi-specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
3	Multi-specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code	No If yes - % of total payments for inpatient services in CY 2011 spent	__Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care	

[6] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[7] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
		__ Full/ Partial Capitation __Other (please specify)	on quality incentive payments. _____	__ use of pharmacy services __ Others (please specify)	
4	Sub - Specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
5	Primary Care	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
6	Primary Care	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0~5%	x Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care x use of pharmacy services x Others (please specify)	Quality/Member Satisfaction
7	Sub - Specialty	_ X _ Procedure-based methodology – using CPT, plan,	No	__ Visit/Volume Reduction __use of ancillary/referred services	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
		provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments.	__ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
8	Sub - Specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
9	Multi-specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
10	Multi-specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Additional Questions for Professional Groups

1. List the five most common areas of quality and service incentives in your company's professional group contracts:
   i. HEDIS (diabetes, breast cancer screening, colonoscopy, etc.)
   ii. HCHAPS
   iii. EMR adoption
   iv. Inpatient and ER use
   v. Rx Management
2. Percent of total payments to these ten professional groups in CY 2011 spent on quality incentive payments. ___<1%_____

3. Percent of total payments to these ten professional groups in CY 2011 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): ___n/a_____

4. Estimated Payments in first six months of CY 2011 for Professional Group Services as % of what Medicare would have paid for similar set. of services: 122% (i.e. 22% over Medicare Reimbursement) (add comments or caveats)

   The analysis was conducted using a claim line level comparison between allowed reimbursement and Medicare fee information obtained from RBRVS tables as well as Medicare ancillary schedules such as clinical lab, DME etc. Anesthesia services were also included. Procedures that Medicare does not reimburse but supplies RVU information for, such as preventive medicine and consults codes, are included at the RVU level rate for the Medicare comparison. Claims lines that do not have RBRVS/Ancillary schedule information were dropped from the analysis.

   Additionally, Tufts Health Plan has concerns that the results may be skewed due to particular mix of services for providers. Based on the concerns listed above it is our belief that a Medicare comparison might not result in a benchmark that is useful and could lead to unintended and/or misinterpreted conclusions that if made public could impact certain contract negotiations by putting upward pressure on unit costs.

Other Comments on Quality/Efficiency Incentives in Professional Group Contracting:

Selected Contract Sections Showing Compliance To OHIC Conditions

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Effective for dates of service on or after January 1, 2011

Office of the Health Insurance Commissioner Conditions

Pay-For-Performance: **[Redacted]** is available for the Hospital to earn based upon quality and/or efficiency measures **[redacted]**.

Case Rates: In the event **[redacted]** parties agree to meet to discuss the potential to transition to efficiency based payment methodologies (e.g., DRG, APC) in a manner that **[redacted]**.

Administrative Efficiency: Tufts Health Plan agrees to assign a Contract Specialist to provide ongoing contract related support through the term of the agreement to help mitigate contract related issues.

The Hospital agrees to work with and communicate issues to the Contract Specialist on an ongoing basis and work in good faith to resolve contract related issues in a timely manner.

Communication: During calendar year 2011 parties agree to formalize clinical communication that promotes and measures improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers.

Public Release of Contract Terms: Parties agree to allow the public release of terms outlined in this agreement if compelled by State regulatory authorities.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

1. Please provide an excel spreadsheet in the following format, detailing the 2011 actual and 2013 requested small and large group administrative costs pmpm, allocated among the NAIC- financial statement administrative cost categories. Please explain any significant changes from the financial filing for 2011 (increases/decreases of more than five percent in a particular category).

RI Insured PPO	2011 Actual (from filed financial statements)		2013 Proposed		% Change	
	Small Group	Large Group	Small Group	Large Group	Small Group	Large Group
Total Estimated Member Months	6,778	28,008	5,732	26,480	-15.4%	-5.5%
Total Estimated Premiums ($pmpm)	$382.46	$404.51	$425.43	$449.88	11.2%	11.2%
Total General Administrative Expense	$37.84	$37.94	$45.37	$43.14	19.9%	13.7%
Total Cost Containment Expense	$10.43	$9.64	$11.73	$11.73	12.5%	21.7%
Total Other Claim Adjustment Expense ($pmpm)	$7.99	$7.38	$8.98	$8.98	12.5%	21.7%
Breakdown of General Administrative Expense ($pmpm)						
a. Payroll and benefits	$2.94	$2.72	$3.31	$3.31	12.5%	21.7%
b. Outsourced Services (EDP, claims etc.)	$0.09	$0.09	$0.10	$0.10	12.5%	21.7%
c. Auditing and consulting	$8.02	$7.42	$9.03	$9.03	12.5%	21.7%
d. Commissions	$13.32	$14.30	$14.35	$12.12	7.7%	-15.2%
e. Marketing and Advertising	$1.76	$1.63	$1.98	$1.98	12.5%	21.7%
f. Legal Expenses	$0.17	$0.16	$0.19	$0.19	12.5%	21.7%
g. Taxes, Licenses and Fees	$8.72	$9.22	$13.43	$13.43	54.0%	45.6%
h. Reimbursements by Uninsured Plans	$0.00	$0.00	$0.00	$0.00	0.0%	0.0%
i. Other Admin Expenses	$2.82	$2.42	$2.99	$2.99	6.1%	23.6%

Notes

1. The expense in any given administrative category may vary from year to year due to the small size of Tufts Health Plan's PPO block of business in Rhode Island. In aggregate, however, total admin has increased less than about 3% per year.

2. Please also provide an excel spreadsheet in the following format; detailing actual calendar year 2007-2011 fully insured commercial administrative costs, in accordance with the following table. This should be consistent with the annual statement filings to OHIC for administrative costs, providing additional detail on the components of administrative costs using the categories defined by NAIC financial statement and as allocated to commercially insured business only. Specifically, the information provided should agree with the "Exhibit of Premiums, Enrollment and Utilization" and the "Analysis of Operations by Line of Business" schedules included in the Annual Statements on file with OHIC. Where there are variance, a reconciliation and explanation should be provided.

Fully Insured Commercial Administrative Cost History

RI Insured PPO	2007	2008	2009	2010	2011
Total Premiums			12,373,810	17,393,107	13,921,729
Total General Administrative Expense			1,929,424	1,887,787	1,319,190
General Admin Exp. Ratio			15.6%	10.9%	9.5%
Total Fully Insured Member Months			33,738	45,416	34,786
General Administrative Expense ($pmpm)			$57.19	$41.57	$37.92
Breakdown of General Administrative Expense ($pmpm)					
a. Payroll and benefits			$3.37	$2.49	$2.76
b. Outsourced Services (EDP, claims etc.)			$0.01	$0.01	$0.09
c. Auditing and consulting			$5.92	$4.93	$7.54
d. Commissions			$18.10	$16.49	$14.11
e. Marketing and Advertising			$2.52	$1.72	$1.66
f. Legal Expenses			$0.08	$0.11	$0.16
g. Taxes, Licenses and Fees			$7.34	$8.74	$9.12
h. Reimbursements by Uninsured Plans			$0.00	$0.00	$0.00
i. Other Admin Expenses			$19.85	$7.09	$2.50
Cost Containment Expense			179,767	385,924	340,764
Other Claim Adjustment Expense			236,579	369,709	260,894
Total Self Insured Member Months for all Affiliated Companies doing business in RI			113,694	0	662

RI Insured PPO

3. At the request of OHIC's Health Insurance Advisory Council, please provide brief answers to the following questions

- **In general and net of new taxes and fees, why should the rate of increase in Health Plan administrative costs exceed the general inflation rate?**

  Administrative expenses in total in a given year are adjusted for inflation, membership growth or loss and increases or decreases in corporate projects, which are often driven by regulatory requirements and government mandates. As a general practice, to set administrative expense targets for the annual financial plan, fixed administrative costs are grown at an inflationary rate. Variable administrative costs are then developed by applying inflation to the variable pmpm rate and then multiplying the inflated pmpm rate by planned member months. While those are the initial steps to develop targets, each administrative function is reviewed in detail to identify potential administrative cost savings and targets are adjusted accordingly.

- **What percentage of administrative costs does your organization consider fixed for the next five years? Provide detail by expense categories.**

  For the total company, we currently consider 58% of our costs fixed as follows:

Fixed Administrative Costs by Category:	
Network Management	2%
Sales and Marketing	4%
Clinical Services	5%
Operations	5%
IT & Business Effectiveness	8%
Corporate Projects	14%
Fixed Overhead and Other	20%
Total Fixed Administrative Expenses	58%

- **What administrative services are used by fully insured members that are not used by self-insured clients (e.g. broker commissions) and what are the estimated total costs ($pmpm) for those services?**

  Administrative costs for fully insured membership include expenses associated with medical cost containment ($9.80 pmpm), whereas in most cases self-insured clients bear these costs directly. Broker commissions ($14.11 pmpm) are also not applicable to most self-insured clients.

- **What does your plan use as its pmpm benchmarks or price points for commercial insurance administrative costs and why?**

We periodically participate in the benchmarking survey used to develop the *Sherlock Expense Evaluation Reports* (SEER) which are viewed as the definitive benchmarks for the functional areas of health plan administration. The Sherlock Expense Evaluation Reports (SEER) supply comprehensive and highly granular financial and operational metrics.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Health System Improvements Survey

The State of Rhode Island Office of the Health Insurance Commissioner Regulation 2 lists standards to be used by the Health Insurance Commissioner (Commissioner) for the assessment of the conduct of commercial health insurance issuers in Rhode Island for their efforts aimed at improving the efficiency and quality of health care delivery and increasing access to health care services. The standards include the following issuer activities:

1. Directing resources, including financial contributions, toward system-wide improvements in the state's health care system related to quality, access and efficiency, including providing support to local collaboratives, organizations, and initiatives that promote these three goals

2. Participating in the development and implementation of public policy issues related to health

To assist the Commissioner in this assessment, as part of the 2012 small and large employer group rate factor review process for commercial health insurance issuers in Rhode Island, please itemize and quantify your organization's contributions of finances and other material assets to these efforts in Rhode Island in calendar year 2011 in the following table.[1]

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
Funding	Grants provided by the Tufts Health Plan Foundation and Community Relations to the following RI organizations to support wellness and safety initiatives • **Best Buddies International** *Best Buddies Intergenerational College Project* Grant Amount: $20,000 • **Mount St. Rita Health Centre** *Blessings in a Back Pack* Grant Amount: $5,000 • **Bethany Home of Rhode Island Inc.**	**$515,724**

[1] The contributions can be to any entity other than a provider to improve medical and prevention services for all Rhode Islanders and to promote a coherent, integrated, and efficient statewide health care system.

State of Rhode Island Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920-4407
(401) 462-9640
(401) 462-9645 (Fax)
www.ohic.ri.gov

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
	Bethany Home Cares Grant Amount: $43,036 • **Homefront Health Care** *HIP-SAFE (Homefront Intervention to Prevent Slips & Falls in Elders)* Grant Amount: $59,438 • **Rhode Island Free Clinic Inc.** *Healthy Lifestyles for Today and Tomorrow* Grant Amount: $60,000 • **The Providence Center** *InShape Seniors* Grant Amount: $42,000 • **Ocean State Center for Independent Living (OSCIL)** *Home Sweet Accessible Home* Grant Amount: $40,000 • **Westbay Community Action Inc.** *Elder Safety* Grant Amount: $42,000 • **Rhode Island Quality Institute** *Health Information Exchange Support* Grant Amount: $25,000 • **EMR Payments** $179,250	

Participation in RI initiatives, programs and organizations	The goals of these programs, initiatives and organizations is to improve quality and/or transform primary care in the state:
	• CSI/Beacon (Project director, project manager, and nurse case manager support) $38,329
	• Value of Resource Time in Various Programs (Estimate of $30,000 for 0.2 FTE for 2011)
	  ○ RI DOH Medical Director meetings
	  ○ RI Quality Partners Safe Transitions
	  ○ RI Senate Commission on Hospital Payment Reform
	  ○ RIQI Board of Directors
	  ○ RI CSI Beacon Executive Committee
		$68,329

Thank you for your cooperation.

Tufts Insurance Company

Small Group Rate Filing -- Effective Date January 1, 201

Part 1. Historical Information

Experience Period for Developing Rates	
From	To
01/01/2009	12/31/2011

Utilization/Experience Data by Quarter (Last 12 Available Quarters)

Quarter	End Date	IP Days	Member Months	Earned Premium	Incurred Claims Total	Incurred Claims IP	Incurred Claims OP	Incurred Claims Primary Care	Incurred Claims Other M/S	Incurred Claims Rx	Loss Ratio	Quality Improvement Expense*	Other Cost Containment Expense*	Other Claim Adjustment Expense*	Other Operating Expense*	Investment Income Credit	Commissions	Contribution to Reserves
1 (Oldest)	03/31/2009	76	1,102	$405,221	$701,562	$468,348	$61,421	$23,191	$111,445	$37,158	175.4%	$9,009	$4,958	$6,486	$37,439	N/A	$23,873	($378,107)
2	06/30/2009	132	3,007	$1,042,273	$1,331,406	$573,675	$187,236	$57,272	$406,296	$106,926	130.1%	$24,583	$13,529	$17,698	$102,160	N/A	$65,141	($512,244)
3	09/30/2009	36	3,800	$1,293,844	$959,092	$138,405	$306,968	$78,223	$302,586	$132,911	76.5%	$31,066	$17,096	$22,365	$129,101	N/A	$82,319	$52,803
4	12/31/2009	139	4,217	$1,447,488	$1,190,529	$296,776	$260,194	$86,067	$392,450	$155,042	84.7%	$34,917	$19,215	$25,137	$144,679	N/A	$92,523	($59,511)
5	03/31/2010	21	3,760	$1,268,976	$849,611	$81,861	$247,686	$75,560	$304,262	$140,242	69.3%	$29,734	$14,111	$18,460	$104,600	N/A	$74,460	$177,999
6	06/30/2010	28	2,719	$939,442	$760,321	$179,215	$171,752	$60,517	$242,771	$106,065	83.2%	$21,554	$10,229	$13,382	$75,765	N/A	$53,974	$4,217
7	09/30/2010	17	2,411	$860,083	$608,511	$54,219	$183,883	$57,653	$220,731	$92,024	73.0%	$19,020	$9,027	$11,808	$66,961	N/A	$47,629	$97,127
8	12/31/2010	48	2,255	$824,757	$770,902	$162,112	$182,154	$57,529	$247,289	$121,818	95.6%	$17,823	$8,459	$11,066	$62,710	N/A	$44,633	($90,836)
9	03/31/2011	49	1,940	$720,955	$798,139	$190,611	$203,824	$50,202	$243,663	$109,840	112.6%	$13,829	$8,688	$10,627	$51,199	N/A	$26,167	($187,695)
10	06/30/2011	13	1,781	$671,036	$426,035	$25,535	$112,155	$39,990	$161,042	$87,312	65.4%	$12,695	$7,976	$9,756	$47,003	N/A	$24,022	$143,548
11	09/30/2011	63	1,540	$604,262	$658,934	$178,642	$175,090	$35,358	$190,531	$79,314	110.9%	$10,977	$6,896	$8,436	$40,643	N/A	$20,772	($142,397)
12	12/31/2011	42	1,433	$573,713	$402,302	$21,777	$111,229	$37,188	$161,666	$70,442	71.9%	$10,215	$6,417	$7,850	$37,819	N/A	$19,329	$89,781

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3- Analysis of Expenses and/or to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1

If any of the historical information reported is different from that period as reported in the prior rate filing, please provide a reconciliation and explanation showing the amount of each element of difference.

Notes:
1. The Other Operating Expenses shown above include taxes, licenses and fees, which were excluded in previous filings for the same time periods
2. Primary care claims definition has been revised to match the Primary Care Spend report
3. Expenses such as network access fee, COB and claims interest are moved from Other M/S claims to administrative expenses according to NAIC definition
4. Claims Total differences from the previous filings for the same time periods are due to updated IBNR factors that reflect more up to date claims payment, as well as the revision to the Other M/S claims definition
5. Loss ratio is calculated as (Incurred Claims Total + Quality Improvement Expense) / Earned Premium

Part 2. Prospective Information

A. 2013 Trend Factors for Projection Purposes (Annualized)

	IP	OP	Primary Care	Other M/S	Rx	Weighted Total
Total	5.2%	6.7%	5.4%	4.7%	4.7%	5.4%
Price Only	3.6%	3.4%	3.3%	1.8%	0.8%	2.6%
Utilization	1.5%	3.2%	2.0%	2.9%	3.9%	2.8%
Other**						
Other**						
Other**						
Weights	20.4%	26.5%	9.4%	26.3%	17.4%	100%

** All elements should add or compound to the total. If anything is to be reported as "Other" please provide a description.

2012 Trend Factors for Projection Purposes (Annualized)

	IP	OP	Primary Care	Other M/S	Autism Mandate	Rx	Weighted Total
Total	5.9%	7.6%	6.4%	4.8%	0.2%	0.3%	5.3%
Price Only	3.6%	3.7%	4.1%	1.3%		-3.6%	1.9%
Utilization	2.2%	3.8%	2.2%	3.5%		4.0%	3.3%
Other**							
Other**							
Other**							
Weights	20.2%	24.7%	8.4%	29.3%		17.4%	100%

** All elements should add or compound to the total. If anything is to be reported as "Other" please provide a description.

B. The following items for the period to which the rate filing applies, by quarter:

5.500% 7.0000% #########

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %
1	01/01/2013	6.1%	85.9%	0.0%	1.6%	1.1%	1.4%	4.5%	3.2%	0.0%	2.3%
2	04/01/2013	5.8%	85.9%	0.0%	1.6%	1.1%	1.4%	4.5%	3.2%	0.0%	2.3%

3	07/01/2013	5.9%	85.9%	0.0%	1.6%	1.1%	1.4%	4.5%	3.2%	0.0%	2.3%
4	10/01/2013	6.1%	85.9%	0.0%	1.6%	1.1%	1.4%	4.5%	3.2%	0.0%	2.3%
Weighted Average		6.0%	85.9%	0.0%	1.6%	1.1%	1.4%	4.5%	3.2%	0.0%	2.3%

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %
1	01/01/2012	3.4%	86.5%	0.0%	1.1%	0.8%	1.1%	5.0%	3.2%	0.0%	2.3%
2	04/01/2012	3.0%	86.5%	0.0%	1.1%	0.8%	1.1%	5.0%	3.2%	0.0%	2.3%
3	07/01/2012	4.0%	86.5%	0.0%	1.1%	0.8%	1.1%	5.0%	3.2%	0.0%	2.3%
4	10/01/2012	6.6%	86.5%	0.0%	1.1%	0.8%	1.1%	5.0%	3.2%	0.0%	2.3%
Weighted Average		4.2%	86.5%	0.0%	1.1%	0.8%	1.1%	5.0%	3.2%	0.0%	2.3%

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3 - Analysis of Expenses and to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1
The sum of the expenses, commissions, contributions to reserves, investment income credit, taxes and the medical loss ratio should be 100%.

C. Average Rate Increase Components

The following items should reconcile to the Weighted Average Percent Rate Increase for the year:

	Price	Utilization, Mix	Total
Hospital Inpatient Price	0.6%	0.3%	0.9%
Hospital Outpatient	0.8%	0.7%	1.5%
Primary Care	0.3%	0.2%	0.4%
Med/Surg Other Than Primary Care	0.4%	0.6%	1.0%
Pharmacy	0.1%	0.6%	0.7%
Administrative Expense (Aggregated)			0.6%
Contribution to Reserves			0.0%
Taxes and Assessments			0.2%
Legally Mandated Changes			0.0%
Prior Period Adjustment (+/-)			0.6%
Total			6.0%

Note:
1. Due to the lack of credible experience, manual rates are developed by trending forward prior base rates to reflect trend changes. Therefore, depending on the timing of trend change, rate increases may be different from trend increase. The difference is reflected as Prior Period Adjustment above.

Part 3. Retrospective Reconciliation of Experience with Filed Factors

	Filed Data[1]					PMPM Increase[2]		Standard Plan PMPM[3]		Standard Plan Increase[4]		Approved		Loss Ratio	
Year	Member Months	Earned Premium	Incurred Claims Total	Premium PMPM	Claims PMPM	Premium	Claims	Premium	Claims	Premium	Claims	Trend Increase%	Contrib to Reserves%	Actual%	Filed%
2009	12,126	4,188,825	4,282,166	$345.44	$353.14			376.24	576.75			9.7%	0%	102.2%	87.0%
2010	11,145	3,893,259	3,077,477	$349.33	$276.13	1.1%	-21.8%	354.15	284.33	-5.9%	-50.7%	9.5%	0%	79.0%	87.0%
2011	6,694	2,569,965	2,333,127	$383.92	$348.54	9.9%	26.2%	327.93	784.15	-7.4%	175.8%	9.2%	0%	90.8%	87.6%

[1] Corresponds to historical Information data in Part 1 above
[2] Percent increase compared to prior year
[3] For most commonly held plan of benefits in 2010 and for the same plan of benefits in 2011
[4] Percent increase compared to prior year

Note:
1. Filed loss ratio for CY 2011 is the sum of the expected pure medical cost ratio and expected quality improvement expenses % in 2011 rate factor filing

Rhode Island Health Statement Supplement

Cover Sheet

Company Name	**Tufts Associated Health Maintenance Organizations & Tufts Insurance Company**		
Enter NAIC#	**95688 & 60177**	**Reporting Year**	**2011**
Enter DBR registration # (TPAs)			

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Office of the Health Insurance Commissioner
1511 Pontiac Ave, Building #69 first floor
Cranston, RI 02920
(401) 462-9517
(401) 462-9645 (fax)
HealthInsInquiry@ohic.ri.gov

Line of Business Exhibit

Field			1 Comprehensive/Major medical			2 ASO/TPA			3 Stop loss/ Excess loss/Reinsurance			4 Medicare Part C			5 Medicare Part D			6 Medicare Supplement Policies			7 Medicaid/Other public			8 Student blanket			9 Dental Only			10 Other Medical Non-Comprehensive			11 Total (Across all lines of business)		
			RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
1		**Membership Data**																																
		Number of Polices or Certificates	197	-	197	1	-	1			-			-	91		91	3	-	3			-			-			-			-	292	-	292
		Number of Covered Lives	3,936	737	4,673	299	29	328			-			-	91		91	5	-	5			-			-			-			-	4,331	766	5,097
		Member Months	48,618	8,909	57,527	603	59	662			-			-	1,062		1,062	60	-	60			-			-			-			-	50,343	8,968	59,311
		Number of Polices or Certificates (**Plans with PD benefits**)	197	-	197	1	-	1	-	-	-	-	-	-	91	-	91	3	-	3	-	-	-	-	-	-	-	-	-	-	-	-	292	-	292
		Number of Covered Lives (**Plans with PD benefits**)	3,936	737	4,673	299	29	328	-	-	-	-	-	-	91	-	91	5	-	5	-	-	-	-	-	-	-	-	-	-	-	-	4,331	766	5,097
		Member Months (**Plans with PD benefits**)	48,618	8,909	57,527	603	59	662	-	-	-	-	-	-	1,062	-	1,062	60	-	60	-	-	-	-	-	-	-	-	-	-	-	-	50,343	8,968	59,311
2		**Premiums/Claims**																																
		Premium	19,382,569	3,553,785	22,936,354	162,614	18,088	180,702			-			-	146,221		146,221	23,160	-	23,160			-			-			-			-	19,714,564	3,571,873	23,286,437
		Claims/Medical Expenses	17,496,249	3,228,233	20,724,482	139,151	15,072	154,222			-			-	405,690		405,690	20,052	-	20,052			-			-			-			-	18,061,142	3,243,305	21,304,446
3		**Inpatient Facility**																																
		Hospital																																
	1	In-state	3,158,748	206,043	3,364,791	17,550	-	17,550			-			-			-	-	-	-			-			-			-			-	3,176,298	206,043	3,382,341
	2	Out-of-state	540,726	359,998	900,724	-	-	-			-			-			-	-	-	-			-			-			-			-	540,726	359,998	900,724
	3	Total (Lines 1 + 2)	3,699,474	566,041	4,265,515	17,550	-	17,550	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3,717,024	566,041	4,283,065
		SNF																																
	4	In-state	33,154	5,624	38,778	-	-	-			-			-			-	-	-	-			-			-			-			-	33,154	5,624	38,778
	5	Out-of-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	6	Total (Lines 4 + 5)	33,154	5,624	38,778	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	33,154	5,624	38,778
		Other																																
	7	In-state	1,167	-	1,167	-	-	-			-			-			-	-	-	-			-			-			-			-	1,167	-	1,167
	8	Out-of-state	-	12,761	12,761	-	-	-			-			-			-	-	-	-			-			-			-			-	-	12,761	12,761
	9	Total (Lines 7 + 8)	1,167	12,761	13,928	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,167	12,761	13,928
	10	**Total Inpatient Facility (Lines 3 + 6 + 9)**	3,733,795	584,427	4,318,222	17,550	-	17,550	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3,751,345	584,427	4,335,772
4		**Outpatient Facility**																																
		Hospital																																
	11	In-state	3,352,396	210,704	3,563,100	22,675	916	23,591			-			-			-	1,633	-	1,633			-			-			-			-	3,376,704	211,620	3,588,324
	12	Out-of-state	317,396	538,951	856,347	1,088	1,834	2,922			-			-			-	-	-	-			-			-			-			-	318,484	540,785	859,269
	13	Total (Lines 11 + 12)	3,669,791	749,655	4,419,447	23,763	2,749	26,512	-	-	-	-	-	-	-	-	-	1,633	-	1,633	-	-	-	-	-	-	-	-	-	-	-	-	3,695,188	752,404	4,447,593
		SNF																																
	14	In-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	15	Out-of-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	16	Total (Lines 14 + 15)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
		Freestanding Ambulatory Care Facility																																
	17	In-state	747,250	53,967	801,218	1,893	-	1,893			-			-			-	-	-	-			-			-			-			-	749,143	53,967	803,110
	18	Out-of-state	168,850	101,890	270,740	-	4,631	4,631			-			-			-	-	-	-			-			-			-			-	168,850	106,521	275,371
	19	Total (Lines 17 +18)	916,100	155,858	1,071,958	1,893	4,631	6,524	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	917,993	160,489	1,078,482
		Other																																
	20	In-state	728,426	17,731	746,156	2,074	115	2,189			-			-			-	310	-	310			-			-			-			-	730,809	17,845	748,655
	21	Out-of-state	146,342	140,799	287,140	945	369	1,314			-			-			-	47	-	47			-			-			-			-	147,334	141,167	288,501
	22	Total (Lines 20 + 21)	874,767	158,529	1,033,296	3,019	484	3,503	-	-	-	-	-	-	-	-	-	357	-	357	-	-	-	-	-	-	-	-	-	-	-	-	878,143	159,013	1,037,156
	23	**Total Outpatient Facility (Lines 13 + 16 + 19 + 22)**	5,460,659	1,064,042	6,524,701	28,676	7,864	36,539	-	-	-	-	-	-	-	-	-	1,990	-	1,990	-	-	-	-	-	-	-	-	-	-	-	-	5,491,325	1,071,906	6,563,231
5		**Primary Care**																																
	24	**Total Primary Care**	1,115,436	219,726	1,335,162	15,201	842	16,043			-			-			-	679	-	679			-			-			-			-	1,131,316	220,567	1,351,883
6		**Pharmacy**																																
	25	**Total Pharmacy**	3,060,587	545,750	3,606,337	44,737	1,491	46,227			-			-	405,690		405,690	10,316	-	10,316			-			-			-			-	3,521,330	547,241	4,068,570
7		**Medical/Surgical other than primary care**																																
	26	In-state	2,373,477	133,824	2,507,301	17,385	1,341	18,726			-			-			-	5,354	-	5,354			-			-			-			-	2,396,216	135,165	2,531,381
	27	Out-of-state	429,183	432,394	861,577	442	1,815	2,257			-			-			-	-	-	-			-			-			-			-	429,625	434,208	863,834
	28	**Total Other Medical/Surgical (Lines 26 + 27)**	2,802,660	566,218	3,368,878	17,828	3,155	20,983	-	-	-	-	-	-	-	-	-	5,354	-	5,354	-	-	-	-	-	-	-	-	-	-	-	-	2,825,841	569,374	3,395,215
8		**All other payments to medical providers**																																
	29	**Total**	1,323,112	248,070	1,571,182	15,159	1,720	16,880			-			-			-	1,714	-	1,714			-			-			-			-	1,339,986	249,790	1,589,776

Field	Market Exhibit (For Comprehensive/Major Medical Line of Business)	1 Individual			2 Small Group			3 Large Group			4 Association			5 Trust			6 Federal Employee Health Benefit Plan			7 Other Health Market			8 Total (Across all markets)		
		RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
	Membership Data																								
	Number of Polices or Certificates	1	-	1	165	-	165	31	-	31			-			-			-			-	197	-	197
	Number of Covered Lives	1	-	1	702	140	842	3,233	597	3,830			-			-			-			-	3,936	737	4,673
1	Member Months	12	-	12	9,473	1,838	11,311	39,133	7,071	46,204			-			-			-			-	48,618	8,909	57,527
	Number of Polices or Certificates (**Plans with PD benefits**)	1	-	1	165	-	165	31	-	31	-	-	-	-	-	-	-	-	-	-	-	-	197	-	197
	Number of Covered Lives (**Plans with PD benefits**)	1	-	1	702	140	842	3,233	597	3,830	-	-	-	-	-	-	-	-	-	-	-	-	3,936	737	4,673
	Member Months (**Plans with PD benefits**)	12	-	12	9,473	1,838	11,311	39,133	7,071	46,204	-	-	-	-	-	-	-	-	-	-	-	-	48,618	8,909	57,527
	Premiums/Claims																								
2	Premium	2,874	-	2,874	3,658,257	690,328	4,348,585	15,721,439	2,863,457	18,584,896			-			-			-			-	19,382,569	3,553,785	22,936,354
	Claims/Medical Expenses	1,660	-	1,660	3,100,638	454,637	3,555,275	14,393,951	2,773,596	17,167,547			-			-			-			-	17,496,249	3,228,233	20,724,482
	Inpatient Facility																								
	Hospital																								
1	In-state	-	-	-	441,217	49,217	490,434	2,717,530	156,826	2,874,356			-			-			-			-	3,158,748	206,043	3,364,791
2	Out-of-state	-	-	-	52,816	12,154	64,969	487,911	347,844	835,755			-			-			-			-	540,726	359,998	900,724
3	Total (Lines 1 + 2)	-	-	-	494,033	61,371	555,404	3,205,441	504,670	3,710,111	-	-	-	-	-	-	-	-	-	-	-	-	3,699,474	566,041	4,265,515
	SNF																								
3 4	In-state	-	-	-	7,542	-	7,542	25,612	5,624	31,236			-			-			-			-	33,154	5,624	38,778
5	Out-of-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
6	Total (Lines 4 + 5)	-	-	-	7,542	-	7,542	25,612	5,624	31,236	-	-	-	-	-	-	-	-	-	-	-	-	33,154	5,624	38,778
	Other																								
7	In-state	-	-	-	-	-	-	1,167	-	1,167			-			-			-			-	1,167	-	1,167
8	Out-of-state	-	-	-	-	-	-	-	12,761	12,761			-			-			-			-	-	12,761	12,761
9	Total (Lines 7 + 8)	-	-	-	-	-	-	1,167	12,761	13,928	-	-	-	-	-	-	-	-	-	-	-	-	1,167	12,761	13,928
10	**Total Inpatient Facility (Lines 3 + 6 + 9)**	-	-	-	501,575	61,371	562,946	3,232,220	523,056	3,755,276	-	-	-	-	-	-	-	-	-	-	-	-	3,733,795	584,427	4,318,222
	Outpatient Facility																								
	Hospital																								
11	In-state	-	-	-	514,964	32,443	547,407	2,837,431	178,261	3,015,692			-			-			-			-	3,352,396	210,704	3,563,100
12	Out-of-state	-	-	-	117,047	54,151	171,198	200,349	484,800	685,149			-			-			-			-	317,396	538,951	856,347
13	Total (Lines 11 + 12)	-	-	-	632,011	86,594	718,605	3,037,780	663,061	3,700,842	-	-	-	-	-	-	-	-	-	-	-	-	3,669,791	749,655	4,419,447
	SNF																								
14	In-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
15	Out-of-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
4 16	Total (Lines 14 + 15)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Freestanding Ambulatory Care Facility																								
17	In-state	-	-	-	160,253	5,262	165,515	586,997	48,705	635,702			-			-			-			-	747,250	53,967	801,218
18	Out-of-state	-	-	-	42,588	11,594	54,182	126,262	90,297	216,558			-			-			-			-	168,850	101,890	270,740
19	Total (Lines 17 + 18)	-	-	-	202,841	16,856	219,698	713,259	139,002	852,260	-	-	-	-	-	-	-	-	-	-	-	-	916,100	155,858	1,071,958
	Other																								
20	In-state	1,420	-	1,420	109,081	7,179	116,260	617,925	10,551	628,476			-			-			-			-	728,426	17,731	746,156
21	Out-of-state	-	-	-	15,956	30,833	46,788	130,386	109,966	240,352			-			-			-			-	146,342	140,799	287,140
22	Total (Lines 20 + 21)	1,420	-	1,420	125,037	38,012	163,048	748,311	120,517	868,828	-	-	-	-	-	-	-	-	-	-	-	-	874,767	158,529	1,033,296
23	**Total Outpatient Facility (Lines 13 + 16 + 19 + 22)**	1,420	-	1,420	959,889	141,462	1,101,351	4,499,350	922,580	5,421,930	-	-	-	-	-	-	-	-	-	-	-	-	5,460,659	1,064,042	6,524,701

5		**Primary Care**																							
	24	**Total Primary Care**	-	-	-	236,566	66,277	302,843	878,870	153,449	1,032,319			-			-			-			-	1,115,436	219,726	1,335,162
6		**Pharmacy**																							
	25	**Total Pharmacy**			-	560,457	63,013	623,470	2,500,130	482,738	2,982,868			-			-			-			-	3,060,587	545,750	3,606,337
7		**Medical/Surgical other than primary care**																							
	26	In-state	107	-	107	500,447	25,883	526,330	1,872,922	107,942	1,980,864			-			-			-			-	2,373,477	133,824	2,507,301
	27	Out-of-state	-	-	-	100,752	54,851	155,604	328,431	377,542	705,973			-			-			-			-	429,183	432,394	861,577
	28	**Total Other Medical/Surgical (Lines 26 + 27)**	107	-	107	601,200	80,734	681,934	2,201,353	485,484	2,686,837	-	-	-	-	-	-	-	-	-	-	-	-	2,802,660	566,218	3,368,878
8		**All other payments to medical providers**																							
	29	**Total**	133	-	133	240,951	41,780	282,732	1,082,028	206,290	1,288,317			-			-			-			-	1,323,112	248,070	1,571,182

2012 Rate Review Process
Areas of Medical Expense Variation

Introductory Remarks

The stated goal of this exercise is to improve OHIC's understanding of the drivers of rising medical spending in Rhode Island by comparing the experience of the issuer's Rhode Island member base to a benchmark. For the purposes of this analysis, we have used our 2011 fully insured MA HMO experience as the benchmark. However, given the size of Tufts Health Plan's membership base in Rhode Island, the results of this comparative analysis will have limited credibility. Our relative costs by area of care have changed significantly in Rhode Island from year to year and are expected to continue to be volatile as our population in this market grows. Although we have commented on the probable causes of each variation listed, these fundamentally reflect a small, immature market compared to a much larger, more mature benchmark and should be interpreted with caution.

1. The top five areas of care, based on *per capita total dollar value* positive variation from the benchmark

Area of Care	Total Excess Spending	PMPM Excess Spending	Comments on Estimated Cause
INPATIENT ACUTE MED/SURG	$1,339,638	$23.29	Attributable to higher utilization (both admits and ALOS), rather than unit cost. High cost claimants identified as having a disproportionately large impact. The higher number of admits may be a consequence of lower than benchmark outpatient professional care.
PHARMACY - Rx MM	$717,042	$12.46	Attributable to higher utilization across tiers and therapeutic classes. Higher utilization driven by more members in RI having prescriptions filled than in the benchmark population, rather than a higher number of prescriptions per member.
OUTPATIENT LABORATORY	$558,538	$9.71	Capitation strategy applied in the benchmark population successfully contains cost.
OUTPATIENT INJECTIONS	$425,609	$7.40	Driven primarily by a difference in payment methodology between RI and the benchmark population. Injection claims in RI are reimbursed on a fee for service basis while in the benchmark population they are reimbursed on a fee for service basis or bundled into an outpatient surgery case payment. More than 50% of the higher RI utilization is associated with outpatient surgery claims, which would not be separately identified in the benchmark population.
OUTPATIENT EMERGENCY ROOM	$406,508	$7.07	Attributable primarily to a higher cost per emergency room encounter. This higher cost per encounter is driven less by higher unit cost in RI and more by the higher number of services delivered within an emergency room encounter compared to the benchmark.

2. The top five areas of care, based on *the percent of positive variation in per capita spending* from the benchmark

Area of Care	Percent of Positive Variation	Total Excess Spending	Comments on Estimated Cause
OUTPATIENT INJECTIONS	158%	$425,609	Driven primarily by a difference in payment methodology as described above.
FREE STANDING HIGH COST RADIOLOGY (MRI, PET, CT)	124%	$130,764	Higher utilization of allied health facilities, along with lower Outpatient Hospital High Cost Radiology utilization, reflects appropriate re-direction of care to lower cost providers.
OUTPATIENT LABORATORY	96%	$558,538	Capitation strategy applied in the benchmark population successfully contains cost.
INPATIENT OTHER	74%	$117,886	Driven by Mental Health/Substance Abuse services. Capitation strategy for inpatient Mental Health/Substance Abuse within the benchmark population effective at containing costs.
OUTPATIENT EMERGENCY ROOM	63%	$406,508	Attributable primarily to the number of services delivered within an emergency room encounter, as described above.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Provider Contracting Practices and Hospital Contracting Conditions Verification Questionnaire

Background

The Health Insurance Advisory Council (HIAC) to the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) has promulgated Affordability Standards for commercial health insurance issuers in Rhode Island.

Health plans will improve the affordability of health care in Rhode Island by focusing their efforts upon provider payment reform, beginning with primary care. Achievement of this goal will not add to overall medical spend in the short-term, and is expected to produce savings thereafter. Specific areas of focus in support of this goal are as follows:

1. Expand and improve the primary care infrastructure in the state—with limitations on ability to pass on cost in premiums
2. Spread Adoption of the "Chronic Care Model" Medical Home
3. Standardize electronic medical record (EMR) incentives
4. Work toward comprehensive payment reform across the delivery system

To support standard four, OHIC has previously issued six conditions for issuer contracts with hospitals in Rhode Island, to be implemented by issuers upon contract execution, renewal, or extension. These are as follows:

1. Utilize unit of service payment methodologies for both inpatient and hospital outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee for service.
2. Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index ("Index"), for all contractual and optional years covered by the contract
3. Provide the opportunity for hospitals to increase their total annual revenue for

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

commercially insured enrollment under the contract by at least additional two percentage points over the previous contract year by improving or attaining mutually agreed-to performance levels for no less than three nationally-accepted clinical quality, service quality or efficiency-based measures.

4. Include terms that define the parties' mutual obligations for greater administrative efficiencies
5. Include terms that promote and measure improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers.
6. Include terms that explicitly relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement.

The purpose of this questionnaire is to assess compliance with standard four of the Affordability Standards and to consider the responses in connection with OHIC's 2012 small and large employer group rate factor review process for commercial health insurance issuers in Rhode Island.

Directions

1. Please fill out all parts of questionnaire.
2. As no providers are identified and no financial details are solicited, none of this information will be considered proprietary or confidential. Should any information or document be considered confidential by the filer, the filer must request approval of the Health Insurance Commissioner. The request must identify the specific information or document (or portion thereof) which the filer considers confidential, accompanied by a factual and legal analysis supporting the request.
3. Questionnaire responses must be verified by filing those portions of each hospital contract which support the survey response. An index or other method of reference must be included to identify which hospital contract documentation relates to each survey response. Any contract excerpts provided will be summarized for review.
4. Please contact OHIC with any questions.

State of Rhode Island Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920-4407
(401) 462-9640
(401) 462-9645 (Fax)
www.ohic.ri.gov
THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

General comment:

Tufts Health Plan has a long standing commitment to investment in payer-provider incentive alignment, and we maintain hospital and physician incentive programs that apply to the vast majority of our network providers. As a relatively new entrant into the RI market, we are at an early stage of incorporating incentive mechanisms into our RI provider contracts. Provider incentive will be a key component of our contracting strategy as we grow our presence in the state of RI.

Tufts Health Plan requests that the information provided in response to this survey be deemed to constitute "trade secrets" within the meaning of the term in section 38-2-2(4)(i)(B) of the Rhode Island General Laws. We have included a footer stating "THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION".

Finally, due to the questionable reliability of certain information provided in our responses, which is explained in further detail below, it is Tufts Health Plan's expectation and understanding that the information provided in this Provider Survey will not be used or considered in OHIC's review of Tufts Health Plan's rates.

Part 1. Hospital Inpatient Services

- **Please fill out one row in the chart below for <u>each</u> general service institution (no specialty care, no rehab) with whom you contract in RI.**
- **Institution means hospital system if all contractual terms other than $ amounts apply identically across all inpatient facilities in the contract.**
- **Incentives refer to activities or measures resulting in additional payments by the insurer.**

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments

[1] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[2] Attach analysis and relevant documentation from contracts to demonstrate compliance status.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
1	3 Years	X DRG X Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	No	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [3]	__ admission reductions __ day reductions __ process/structural changes (e.g. discharge practices) __Others (please specify)	N/A (Contract has not been renegotiated)	
2	3 Years	x DRG x Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.5~1.0%____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
3	3 Years	__DRG __Per Diem x % of Charges __ Bundled Services	No	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

[3] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
		__ Capitation or other budgeting __Others (please specify)		incentive payments. 0.1~0.5%			
4	2 Years	__DRG x Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
5	3 Years	__DRG __Per Diem x % of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	No	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
6	3 Years	__DRG __Per Diem x % of Charges __ Bundled	No	No If yes - % of total payments for inpatient services in CY	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
		Services __ Capitation or other budgeting __Others (please specify)		2011 spent on quality incentive payments. _____			
7	1 Year	__DRG _x_Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. ____ 0-2%	_X_ admission reductions _X_ day reductions __Others (please specify)	Yes, please see attached	
8	3 Years	__DRG _x_Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

Additional Questions for Hospital Inpatient Services

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

1. List the five most common areas of quality and service incentives in your company's inpatient contracts:
(These measures apply to our hospital contracts that combine inpatient and outpatient services.)
   i. Joint Commission measures (e.g., AMI, CHF, pneumonia)
   ii. Leapfrog measures (e.g., CPOD, ICU staffing)
   iii. Prevention of "Never Events"
   iv. Surgical infection rates
   v. Readmission rates
2. Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2011 spent on quality incentive payments. 0.1~1%

3. Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2011 paid through units of service based on efficient resource use (i.e DRG, Capitation, Bundled Service or partial/global budgeting): <5%

4. Estimated Payments in first six months of CY 2011 for Inpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: See comment (add comments or caveats)

   For inpatient services Tufts Health Plan does not currently have the technical capability to benchmark to Medicare IPPS reimbursement. Conducting such analysis would require incremental time, resources and technical capabilities. Benchmarking Tufts Health Plan inpatient payments to Medicare IPPS may yield volatile and potentially unreliable results due to a) differences in reimbursement methodology (Tufts Health Plan reimburses the majority of inpatient claims on either a Per Diem or Percent of Charge basis); b) our relatively small volume of business in Rhode Island; c) mix of services; and d) chargemaster levels to some of the hospitals in Rhode Island. Additionally, it is our belief that a Medicare comparison for some hospitals that perform very specific services, like Obstetrics, will not result in a comparison that is useful and may lead to unintended and/or misinterpreted conclusions.

Other Comments on Quality/Efficiency Incentives in Hospital Inpatient Contracting:

Part 2. Hospital Outpatient Services

- **Please fill out one row in the chart below for each general service institution (no specialty care, no rehab) with whom you contract in RI.**
- **Institution means hospital system if all contractual terms other than dollar amounts apply identically across all inpatient facilities in the contract.**
- **Outpatient Services include any services not involving an admission and covered under the contract with the institution.**

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[4]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - %of total payments for inpatient services in CY 2011 spent on quality incentive payments. [5]	__ Visit/Volume Reduction __ Others (please specify)	
2	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.5~1.0%____	__ Visit/Volume Reduction __ Others (please specify)	
3	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.1~0.5%	__ Visit/Volume Reduction __ Others (please specify)	
4	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality	__ Visit/Volume Reduction __ Others (please specify)	

[4] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[5] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[4]?	Utilization Incentives in Contract: (check all that apply)	Comments
		incentive payments. _____		
5	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
6	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
7	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
8	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	

Additional Questions for Hospital Outpatient Services

1. List the five most common areas of quality and service incentives in your company's hospital outpatient contracts:

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

(These measures apply to our hospital contracts that combine inpatient and outpatient services.)

i. Joint Commission measures (e.g., AMI, CHF, pneumonia)
ii. Leapfrog measures (e.g., CPOD, ICU staffing)
iii. Prevention of "Never Events"
iv. Surgical infection rates
v. Readmission rates

2. Percent of total payments to RI Hospitals for outpatient services in CY 2011 spent on quality incentive payments. 0.1~1%

3. Percent of total payments to RI Hospitals for outpatient services in CY 2011 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): n/a

4. Estimated Payments in first six months of CY 2011 for Outpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: 222% (i.e. 122% over Medicare Reimbursement) (add comments or caveats)

   For Outpatient Services, Tufts Health Plan has the technical capabilities to perform the required benchmarking analysis to Medicare; however, we have concerns about the confidence level in the accuracy of the supplied benchmark. Our concerns are due to a) the allowed reimbursement at a claim level was compared to fee information obtained from OPPS and CMS ancillary schedules such as Clinical Lab, DME etc.; b) we are not able to reprocess our claims through an OPPS Grouper and were limited to a line level reprice based on OPPS/Ancillary fees which means that exact Medicare reimbursement can only be approximated; c) Procedures that do not have a fee on OPPS/Ancillary schedules, or are billed in a different manner to Medicare (e.g., observation) were dropped from the analysis.

   Additionally, Tufts Health Plan has concerns that the results may be skewed due to a few high-volume hospitals and the large number of providers reimbursed on a percent of charges basis – factors that may distort the data due to particular mix of services and chargemaster levels of PAF providers. Based on the concerns listed above it is our belief that a Medicare comparison might not result in a benchmark that is useful and could lead to unintended and/or misinterpreted conclusions that if made public could impact certain contract negotiations by putting upward pressure on unit costs.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Other Comments on Quality/Efficiency Incentives in Hospital Outpatient Contracting:

Part 3: Professional Groups

- **"Professional Groups" is defined as non institutional/non facility groups with a valid contract and a single tax id number.**
- **Please provide information for the top 10 groups (measured by $ paid in 2011), filling in one row per group (10 rows in the table total).**

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	Multi-specialty	x Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [7] _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services _ Others (please specify)	
2	Multi-specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
3	Multi-specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code	No If yes - % of total payments for inpatient services in CY 2011 spent	__Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care	

[6] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[7] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
		__ Full/ Partial Capitation __Other (please specify)	on quality incentive payments. _____	__ use of pharmacy services __ Others (please specify)	
4	Sub - Specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
5	Primary Care	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
6	Primary Care	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0~5%	x Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care x use of pharmacy services x Others (please specify)	Quality/Member Satisfaction
7	Sub - Specialty	_ X _ Procedure-based methodology – using CPT, plan,	No	__ Visit/Volume Reduction __use of ancillary/referred services	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
		provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments.	__ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
8	Sub - Specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
9	Multi-specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
10	Multi-specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Additional Questions for Professional Groups

1. List the five most common areas of quality and service incentives in your company's professional group contracts:
   i. HEDIS (diabetes, breast cancer screening, colonoscopy, etc.)
   ii. HCHAPS
   iii. EMR adoption
   iv. Inpatient and ER use
   v. Rx Management
2. Percent of total payments to these ten professional groups in CY 2011 spent on quality incentive payments. ___<1%_____

3. Percent of total payments to these ten professional groups in CY 2011 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): ___n/a_____

4. Estimated Payments in first six months of CY 2011 for Professional Group Services as % of what Medicare would have paid for similar set. of services: 122% (i.e. 22% over Medicare Reimbursement) (add comments or caveats)

   The analysis was conducted using a claim line level comparison between allowed reimbursement and Medicare fee information obtained from RBRVS tables as well as Medicare ancillary schedules such as clinical lab, DME etc. Anesthesia services were also included. Procedures that Medicare does not reimburse but supplies RVU information for, such as preventive medicine and consults codes, are included at the RVU level rate for the Medicare comparison. Claims lines that do not have RBRVS/Ancillary schedule information were dropped from the analysis.

   Additionally, Tufts Health Plan has concerns that the results may be skewed due to particular mix of services for providers. Based on the concerns listed above it is our belief that a Medicare comparison might not result in a benchmark that is useful and could lead to unintended and/or misinterpreted conclusions that if made public could impact certain contract negotiations by putting upward pressure on unit costs.

Other Comments on Quality/Efficiency Incentives in Professional Group Contracting:

Selected Contract Sections Showing Compliance To OHIC Conditions

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Effective for dates of service on or after January 1, 2011

Office of the Health Insurance Commissioner Conditions

Pay-For-Performance: **[Redacted]** is available for the Hospital to earn based upon quality and/or efficiency measures **[redacted]**.

Case Rates: In the event **[redacted]** parties agree to meet to discuss the potential to transition to efficiency based payment methodologies (e.g., DRG, APC) in a manner that **[redacted]**.

Administrative Efficiency: Tufts Health Plan agrees to assign a Contract Specialist to provide ongoing contract related support through the term of the agreement to help mitigate contract related issues.

The Hospital agrees to work with and communicate issues to the Contract Specialist on an ongoing basis and work in good faith to resolve contract related issues in a timely manner.

Communication: During calendar year 2011 parties agree to formalize clinical communication that promotes and measures improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers.

Public Release of Contract Terms: Parties agree to allow the public release of terms outlined in this agreement if compelled by State regulatory authorities.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

1. Please provide an excel spreadsheet in the following format, detailing the 2011 actual and 2013 requested small and large group administrative costs pmpm, allocated among the NAIC- financial statement administrative cost categories. Please explain any significant changes from the financial filing for 2011 (increases/decreases of more than five percent in a particular category).

RI Insured PPO	2011 Actual (from filed financial statements)		2013 Proposed		% Change	
	Small Group	Large Group	Small Group	Large Group	Small Group	Large Group
Total Estimated Member Months	6,778	28,008	5,732	26,480	-15.4%	-5.5%
Total Estimated Premiums ($pmpm)	$382.46	$404.51	$422.41	$446.68	10.4%	10.4%
Total General Administrative Expense	$37.84	$37.94	$41.93	$39.72	10.8%	4.7%
Total Cost Containment Expense	$10.43	$9.64	$11.65	$11.65	11.7%	20.8%
Total Other Claim Adjustment Expense ($pmpm)	$7.99	$7.38	$8.92	$8.92	11.7%	20.8%
Breakdown of General Administrative Expense ($pmpm)						
a. Payroll and benefits	$2.94	$2.72	$3.29	$3.29	11.7%	20.8%
b. Outsourced Services (EDP, claims etc.)	$0.09	$0.09	$0.10	$0.10	11.7%	20.8%
c. Auditing and consulting	$8.02	$7.42	$8.96	$8.96	11.7%	20.8%
d. Commissions	$13.32	$14.30	$14.24	$12.03	6.9%	-15.8%
e. Marketing and Advertising	$1.76	$1.63	$1.97	$1.97	11.7%	20.8%
f. Legal Expenses	$0.17	$0.16	$0.19	$0.19	11.7%	20.8%
g. Taxes, Licenses and Fees	$8.72	$9.22	$10.21	$10.21	17.1%	10.7%
h. Reimbursements by Uninsured Plans	$0.00	$0.00	$0.00	$0.00	0.0%	0.0%
i. Other Admin Expenses	$2.82	$2.42	$2.97	$2.97	5.4%	22.7%

Notes

1. The expense in any given administrative category may vary from year to year due to the small size of Tufts Health Plan's PPO block of business in Rhode Island. In aggregate, however, total admin has increased less than about 3% per year.

2. Please also provide an excel spreadsheet in the following format; detailing actual calendar year 2007-2011 fully insured commercial administrative costs, in accordance with the following table. This should be consistent with the annual statement filings to OHIC for administrative costs, providing additional detail on the components of administrative costs using the categories defined by NAIC financial statement and as allocated to commercially insured business only. Specifically, the information provided should agree with the "Exhibit of Premiums, Enrollment and Utilization" and the "Analysis of Operations by Line of Business" schedules included in the Annual Statements on file with OHIC. Where there are variance, a reconciliation and explanation should be provided.

Fully Insured Commercial Administrative Cost History

RI Insured PPO	2007	2008	2009	2010	2011
Total Premiums			12,373,810	17,393,107	13,921,729
Total General Administrative Expense			1,929,424	1,887,787	1,319,190
General Admin Exp. Ratio			15.6%	10.9%	9.5%
Total Fully Insured Member Months			33,738	45,416	34,786
General Administrative Expense ($pmpm)			$57.19	$41.57	$37.92
Breakdown of General Administrative Expense ($pmpm)					
a. Payroll and benefits			$3.37	$2.49	$2.76
b. Outsourced Services (EDP, claims etc.)			$0.01	$0.01	$0.09
c. Auditing and consulting			$5.92	$4.93	$7.54
d. Commissions			$18.10	$16.49	$14.11
e. Marketing and Advertising			$2.52	$1.72	$1.66
f. Legal Expenses			$0.08	$0.11	$0.16
g. Taxes, Licenses and Fees			$7.34	$8.74	$9.12
h. Reimbursements by Uninsured Plans			$0.00	$0.00	$0.00
i. Other Admin Expenses			$19.85	$7.09	$2.50
Cost Containment Expense			179,767	385,924	340,764
Other Claim Adjustment Expense			236,579	369,709	260,894
Total Self Insured Member Months for all Affiliated Companies doing business in RI			113,694	0	662

RI Insured PPO

3. At the request of OHIC's Health Insurance Advisory Council, please provide brief answers to the following questions

- **In general and net of new taxes and fees, why should the rate of increase in Health Plan administrative costs exceed the general inflation rate?**

  Administrative expenses in total in a given year are adjusted for inflation, membership growth or loss and increases or decreases in corporate projects, which are often driven by regulatory requirements and government mandates. As a general practice, to set administrative expense targets for the annual financial plan, fixed administrative costs are grown at an inflationary rate. Variable administrative costs are then developed by applying inflation to the variable pmpm rate and then multiplying the inflated pmpm rate by planned member months. While those are the initial steps to develop targets, each administrative function is reviewed in detail to identify potential administrative cost savings and targets are adjusted accordingly.

- **What percentage of administrative costs does your organization consider fixed for the next five years? Provide detail by expense categories.**

  For the total company, we currently consider 58% of our costs fixed as follows:

Fixed Administrative Costs by Category:	
Network Management	2%
Sales and Marketing	4%
Clinical Services	5%
Operations	5%
IT & Business Effectiveness	8%
Corporate Projects	14%
Fixed Overhead and Other	20%
Total Fixed Administrative Expenses	58%

- **What administrative services are used by fully insured members that are not used by self-insured clients (e.g. broker commissions) and what are the estimated total costs ($pmpm) for those services?**

  Administrative costs for fully insured membership include expenses associated with medical cost containment ($9.80 pmpm), whereas in most cases self-insured clients bear these costs directly. Broker commissions ($14.11 pmpm) are also not applicable to most self-insured clients.

- **What does your plan use as its pmpm benchmarks or price points for commercial insurance administrative costs and why?**

We periodically participate in the benchmarking survey used to develop the *Sherlock Expense Evaluation Reports* (SEER) which are viewed as the definitive benchmarks for the functional areas of health plan administration. The Sherlock Expense Evaluation Reports (SEER) supply comprehensive and highly granular financial and operational metrics.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Health System Improvements Survey

The State of Rhode Island Office of the Health Insurance Commissioner Regulation 2 lists standards to be used by the Health Insurance Commissioner (Commissioner) for the assessment of the conduct of commercial health insurance issuers in Rhode Island for their efforts aimed at improving the efficiency and quality of health care delivery and increasing access to health care services. The standards include the following issuer activities:

1. Directing resources, including financial contributions, toward system-wide improvements in the state's health care system related to quality, access and efficiency, including providing support to local collaboratives, organizations, and initiatives that promote these three goals

2. Participating in the development and implementation of public policy issues related to health

To assist the Commissioner in this assessment, as part of the 2012 small and large employer group rate factor review process for commercial health insurance issuers in Rhode Island, please itemize and quantify your organization's contributions of finances and other material assets to these efforts in Rhode Island in calendar year 2011 in the following table.[1]

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
Funding	Grants provided by the Tufts Health Plan Foundation and Community Relations to the following RI organizations to support wellness and safety initiatives • **Best Buddies International** *Best Buddies Intergenerational College Project* Grant Amount: $20,000 • **Mount St. Rita Health Centre** *Blessings in a Back Pack* Grant Amount: $5,000 • **Bethany Home of Rhode Island Inc.**	**$515,724**

[1] The contributions can be to any entity other than a provider to improve medical and prevention services for all Rhode Islanders and to promote a coherent, integrated, and efficient statewide health care system.

State of Rhode Island Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920-4407
(401) 462-9640
(401) 462-9645 (Fax)
www.ohic.ri.gov

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
	Bethany Home Cares Grant Amount: $43,036 • **Homefront Health Care** *HIP-SAFE (Homefront Intervention to Prevent Slips & Falls in Elders)* Grant Amount: $59,438 • **Rhode Island Free Clinic Inc.** *Healthy Lifestyles for Today and Tomorrow* Grant Amount: $60,000 • **The Providence Center** *InShape Seniors* Grant Amount: $42,000 • **Ocean State Center for Independent Living (OSCIL)** *Home Sweet Accessible Home* Grant Amount: $40,000 • **Westbay Community Action Inc.** *Elder Safety* Grant Amount: $42,000 • **Rhode Island Quality Institute** *Health Information Exchange Support* Grant Amount: $25,000 • **EMR Payments** $179,250	

Participation in RI initiatives, programs and organizations	The goals of these programs, initiatives and organizations is to improve quality and/or transform primary care in the state:
	• CSI/Beacon (Project director, project manager, and nurse case manager support) $38,329
	• Value of Resource Time in Various Programs (Estimate of $30,000 for 0.2 FTE for 2011)
	  ○ RI DOH Medical Director meetings
	  ○ RI Quality Partners Safe Transitions
	  ○ RI Senate Commission on Hospital Payment Reform
	  ○ RIQI Board of Directors
	  ○ RI CSI Beacon Executive Committee
		$68,329

Thank you for your cooperation.

Tufts Associated Health Maintenance Organizations, Inc.

Large Group Rate Filing -- Effective Date January 1, 2013

Part 1. Historical Information

Experience Period for Developing Rates	
From	To
01/01/2009	12/31/2011

Utilization/Experience Data by Quarter (Last 12 Available Quarters)

Quarter	End Date	IP Days	Member Months	Earned Premium	Incurred Claims Total	Incurred Claims IP	Incurred Claims OP	Incurred Claims Primary Care	Incurred Claims Other M/S	Incurred Claims Rx	Loss Ratio	Quality Improvement Expense*	Other Cost Containment Expense*	Other Claim Adjustment Expense*	Other Operating Expense*	Investment Income Credit	Commissions	Contribution to Reserves
1 (Oldest)	03/31/2009	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	06/30/2009	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	09/30/2009	10	535	$184,026	$192,099	$35,287	$46,636	$9,661	$54,252	$46,262	106.3%	$3,460	$1,792	$3,129	$17,887	N/A	$5,392	($39,735)
4	12/31/2009	12	1,447	$430,624	$502,287	$47,728	$151,561	$28,866	$196,898	$77,234	118.8%	$9,359	$4,848	$8,464	$48,380	N/A	$14,583	($157,297)
5	03/31/2010	97	2,467	$864,452	$1,023,105	$326,462	$209,880	$42,867	$295,045	$148,851	120.1%	$15,527	$7,277	$12,705	$61,151	N/A	$36,360	($291,672)
6	06/30/2010	99	3,261	$1,167,742	$1,043,432	$207,698	$275,710	$61,342	$316,059	$182,623	91.1%	$20,524	$9,619	$16,793	$80,832	N/A	$48,062	($51,521)
7	09/30/2010	30	3,438	$1,261,070	$986,927	$196,908	$251,210	$63,976	$280,563	$194,270	80.0%	$21,638	$10,141	$17,705	$85,220	N/A	$50,671	$88,769
8	12/31/2010	61	3,539	$1,346,188	$1,045,547	$221,223	$241,432	$84,149	$298,584	$200,160	79.3%	$22,274	$10,439	$18,225	$87,723	N/A	$52,160	$109,820
9	03/31/2011	131	3,964	$1,550,685	$1,260,828	$275,912	$318,962	$84,165	$353,698	$228,092	82.9%	$24,785	$23,748	$23,614	$101,776	N/A	$58,303	$57,630
10	06/30/2011	178	4,476	$1,783,022	$1,915,167	$487,008	$439,723	$97,117	$599,106	$292,213	109.0%	$27,986	$26,816	$26,664	$114,922	N/A	$65,833	($394,366)
11	09/30/2011	137	4,793	$1,894,713	$1,800,129	$422,156	$491,354	$114,320	$476,856	$295,443	96.6%	$29,968	$28,715	$28,552	$123,061	N/A	$70,496	($186,208)
12	12/31/2011	123	4,900	$1,971,233	$2,176,833	$705,730	$479,709	$120,936	$562,108	$308,351	112.0%	$30,637	$29,356	$29,190	$125,808	N/A	$72,069	($492,661)

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3- Analysis of Expenses and/or to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1
If any of the historical information reported is different from that period as reported in the prior rate filing, please provide a reconciliation and explanation showing the amount of each element of difference.

Notes:
1. The Other Operating Expenses shown above include taxes, licenses and fees, which were excluded in previous filings for the same time periods
2. Primary care claims definition has been revised to match the Primary Care Spend report
3. Expenses such as network access fee, COB and claims interest are moved from Other M/S claims to administrative expenses according to NAIC definition
4. Claims Total differences from the previous filings for the same time periods are due to updated IBNR factors that reflect more up to date claims payment, as well as the revision to the Other M/S claims definition
5. Loss ratio is calculated as (Incurred Claims Total + Quality Improvement Expense) / Earned Premium

Part 2. Prospective Information

A. 2013 Trend Factors for Projection Purposes (Annualized)

	IP	OP	Primary Care	Other M/S	Rx	Weighted Total
Total	5.2%	6.7%	5.4%	4.7%	4.7%	5.4%
Price Only	3.6%	3.4%	3.3%	1.8%	0.8%	2.6%
Utilization	1.5%	3.2%	2.0%	2.9%	3.9%	2.8%
Other**						
Other**						
Other**						
Weights	20.4%	26.5%	9.4%	26.3%	17.4%	**100%**

** All elements should add or compound to the total. If anything is to be reported as "Other" please provide a description.

2012 Trend Factors for Projection Purposes (Annualized)

	IP	OP	Primary Care	Other M/S	Autism Mandate	Rx	Weighted Total
Total	5.9%	7.6%	6.4%	4.8%	0.2%	0.3%	5.3%
Price Only	3.6%	3.7%	4.1%	1.3%		-3.6%	1.9%
Utilization	2.2%	3.8%	2.2%	3.5%		4.0%	3.3%
Other**							
Other**							
Other**							
Weights	20.2%	24.7%	8.4%	29.3%		17.4%	**100%**

** All elements should add or compound to the total. If anything is to be reported as "Other" please provide a description.

B. The following items for the period to which the rate filing applies, by quarter:

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %
1	01/01/2013	6.8%	85.7%	0.0%	1.6%	1.4%	1.4%	4.2%	3.0%	0.0%	2.7%
2	04/01/2013	6.5%	85.7%	0.0%	1.6%	1.4%	1.4%	4.2%	3.0%	0.0%	2.7%
3	07/01/2013	6.6%	85.7%	0.0%	1.6%	1.4%	1.4%	4.2%	3.0%	0.0%	2.7%
4	10/01/2013	6.8%	85.7%	0.0%	1.6%	1.4%	1.4%	4.2%	3.0%	0.0%	2.7%
Weighted Average		6.7%	85.7%	0.0%	1.6%	1.4%	1.4%	4.2%	3.0%	0.0%	2.7%

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %
1	01/01/2012	3.4%	87.0%	0.0%	0.9%	0.7%	1.3%	5.1%	3.0%	0.0%	2.0%
2	04/01/2012	3.0%	87.0%	0.0%	0.9%	0.7%	1.3%	5.1%	3.0%	0.0%	2.0%
3	07/01/2012	4.0%	87.0%	0.0%	0.9%	0.7%	1.3%	5.1%	3.0%	0.0%	2.0%
4	10/01/2012	6.6%	87.0%	0.0%	0.9%	0.7%	1.3%	5.1%	3.0%	0.0%	2.0%
Weighted Average		4.2%	87.0%	0.0%	0.9%	0.7%	1.3%	5.1%	3.0%	0.0%	2.0%

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3 - Analysis of Expenses and to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1
The sum of the expenses, commissions, contributions to reserves, investment income credit, taxes and the medical loss ratio should be 100%.

C. Average Rate Increase Components

The following items should reconcile to the Weighted Average Percent Rate Increase for the year:

	Price	Utilization, Mix	Total
Hospital Inpatient Price	0.6%	0.3%	0.9%
Hospital Outpatient	0.8%	0.7%	1.5%
Primary Care	0.3%	0.2%	0.4%
Med/Surg Other Than Primary Care	0.4%	0.6%	1.0%
Pharmacy	0.1%	0.6%	0.7%
Administrative Expense (Aggregated)			0.6%
Contribution to Reserves			0.0%
Taxes and Assessments			0.9%
Legally Mandated Changes			0.0%
Prior Period Adjustment (+/-)			0.6%
Total			6.7%

Note:
1. Due to the lack of credible experience, manual rates are developed by trending forward prior base rates to reflect trend changes. Therefore, depending on the timing of trend change, rate increases may be different from trend increase. The difference is reflected as Prior Period Adjustment above.

Part 3. Retrospective Reconciliation of Experience with Filed Factors

	Filed Data[1]					PMPM Increase[2]		Standard Plan PMPM[3]		Standard Plan Increase[4]		Approved		Loss Ratio	
Year	Member Months	Earned Premium	Incurred Claims Total	Premium PMPM	Claims PMPM	Premium	Claims	Premium	Claims	Premium	Claims	Trend Increase%	Contrib to Reserves%	Actual%	Filed%
2009	1,982	614,650	707,206	$310.12	$356.81			251.04	406.66			9.7%	0%	115.1%	87.0%
2010	12,705	4,639,452	4,178,975	$365.17	$328.92	17.8%	-7.8%	256.39	236.35	2.1%	-41.9%	9.3%	0%	90.1%	87.0%
2011	18,133	7,199,652	7,266,335	$397.05	$400.72	8.7%	21.8%	313.93	293.50	22.4%	24.2%	9.2%	0%	100.9%	87.9%

[1] Corresponds to historical Information data in Part 1 above
[2] Percent increase compared to prior year
[3] For most commonly held plan of benefits in 2010 and for the same plan of benefits in 2011
[4] Percent increase compared to prior year

Note:
1. Filed loss ratio for CY 2011 is the sum of the expected pure medical cost ratio and expected quality improvement expenses % in 2011 rate factor filing

Rhode Island Health Statement Supplement

Cover Sheet

Company Name	**Tufts Associated Health Maintenance Organizations & Tufts Insurance Company**		
Enter NAIC#	**95688 & 60177**	**Reporting Year**	**2011**
Enter DBR registration # (TPAs)			

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Office of the Health Insurance Commissioner
1511 Pontiac Ave, Building #69 first floor
Cranston, RI 02920
(401) 462-9517
(401) 462-9645 (fax)
HealthInsInquiry@ohic.ri.gov

Line of Business Exhibit

Field			1 Comprehensive/Major medical			2 ASO/TPA			3 Stop loss/ Excess loss/Reinsurance			4 Medicare Part C			5 Medicare Part D			6 Medicare Supplement Policies			7 Medicaid/Other public			8 Student blanket			9 Dental Only			10 Other Medical Non-Comprehensive			11 Total (Across all lines of business)		
			RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
1		**Membership Data**																																
		Number of Polices or Certificates	197	-	197	1	-	1			-			-	91		91	3	-	3			-			-			-			-	292	-	292
		Number of Covered Lives	3,936	737	4,673	299	29	328			-			-	91		91	5	-	5			-			-			-			-	4,331	766	5,097
		Member Months	48,618	8,909	57,527	603	59	662			-			-	1,062		1,062	60	-	60			-			-			-			-	50,343	8,968	59,311
		Number of Polices or Certificates (**Plans with PD benefits**)	197	-	197	1	-	1	-	-	-	-	-	-	91	-	91	3	-	3	-	-	-	-	-	-	-	-	-	-	-	-	292	-	292
		Number of Covered Lives (**Plans with PD benefits**)	3,936	737	4,673	299	29	328	-	-	-	-	-	-	91	-	91	5	-	5	-	-	-	-	-	-	-	-	-	-	-	-	4,331	766	5,097
		Member Months (**Plans with PD benefits**)	48,618	8,909	57,527	603	59	662	-	-	-	-	-	-	1,062	-	1,062	60	-	60	-	-	-	-	-	-	-	-	-	-	-	-	50,343	8,968	59,311
2		**Premiums/Claims**																																
		Premium	19,382,569	3,553,785	22,936,354	162,614	18,088	180,702			-			-	146,221		146,221	23,160	-	23,160			-			-			-			-	19,714,564	3,571,873	23,286,437
		Claims/Medical Expenses	17,496,249	3,228,233	20,724,482	139,151	15,072	154,222			-			-	405,690		405,690	20,052	-	20,052			-			-			-			-	18,061,142	3,243,305	21,304,446
3		**Inpatient Facility**																																
		Hospital																																
	1	In-state	3,158,748	206,043	3,364,791	17,550	-	17,550			-			-			-	-	-	-			-			-			-			-	3,176,298	206,043	3,382,341
	2	Out-of-state	540,726	359,998	900,724	-	-	-			-			-			-	-	-	-			-			-			-			-	540,726	359,998	900,724
	3	Total (Lines 1 + 2)	3,699,474	566,041	4,265,515	17,550	-	17,550	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3,717,024	566,041	4,283,065
		SNF																																
	4	In-state	33,154	5,624	38,778	-	-	-			-			-			-	-	-	-			-			-			-			-	33,154	5,624	38,778
	5	Out-of-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	6	Total (Lines 4 + 5)	33,154	5,624	38,778	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	33,154	5,624	38,778
		Other																																
	7	In-state	1,167	-	1,167	-	-	-			-			-			-	-	-	-			-			-			-			-	1,167	-	1,167
	8	Out-of-state	-	12,761	12,761	-	-	-			-			-			-	-	-	-			-			-			-			-	-	12,761	12,761
	9	Total (Lines 7 + 8)	1,167	12,761	13,928	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,167	12,761	13,928
	10	**Total Inpatient Facility (Lines 3 + 6 + 9)**	3,733,795	584,427	4,318,222	17,550	-	17,550	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3,751,345	584,427	4,335,772
4		**Outpatient Facility**																																
		Hospital																																
	11	In-state	3,352,396	210,704	3,563,100	22,675	916	23,591			-			-			-	1,633	-	1,633			-			-			-			-	3,376,704	211,620	3,588,324
	12	Out-of-state	317,396	538,951	856,347	1,088	1,834	2,922			-			-			-	-	-	-			-			-			-			-	318,484	540,785	859,269
	13	Total (Lines 11 + 12)	3,669,791	749,655	4,419,447	23,763	2,749	26,512	-	-	-	-	-	-	-	-	-	1,633	-	1,633	-	-	-	-	-	-	-	-	-	-	-	-	3,695,188	752,404	4,447,593
		SNF																																
	14	In-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	15	Out-of-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	16	Total (Lines 14 + 15)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
		Freestanding Ambulatory Care Facility																																
	17	In-state	747,250	53,967	801,218	1,893	-	1,893			-			-			-	-	-	-			-			-			-			-	749,143	53,967	803,110
	18	Out-of-state	168,850	101,890	270,740	-	4,631	4,631			-			-			-	-	-	-			-			-			-			-	168,850	106,521	275,371
	19	Total (Lines 17 +18)	916,100	155,858	1,071,958	1,893	4,631	6,524	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	917,993	160,489	1,078,482
		Other																																
	20	In-state	728,426	17,731	746,156	2,074	115	2,189			-			-			-	310	-	310			-			-			-			-	730,809	17,845	748,655
	21	Out-of-state	146,342	140,799	287,140	945	369	1,314			-			-			-	47	-	47			-			-			-			-	147,334	141,167	288,501
	22	Total (Lines 20 + 21)	874,767	158,529	1,033,296	3,019	484	3,503	-	-	-	-	-	-	-	-	-	357	-	357	-	-	-	-	-	-	-	-	-	-	-	-	878,143	159,013	1,037,156
	23	**Total Outpatient Facility (Lines 13 + 16 + 19 + 22)**	5,460,659	1,064,042	6,524,701	28,676	7,864	36,539	-	-	-	-	-	-	-	-	-	1,990	-	1,990	-	-	-	-	-	-	-	-	-	-	-	-	5,491,325	1,071,906	6,563,231
5		**Primary Care**																																
	24	**Total Primary Care**	1,115,436	219,726	1,335,162	15,201	842	16,043			-			-			-	679	-	679			-			-			-			-	1,131,316	220,567	1,351,883
6		**Pharmacy**																																
	25	**Total Pharmacy**	3,060,587	545,750	3,606,337	44,737	1,491	46,227			-			-	405,690		405,690	10,316	-	10,316			-			-			-			-	3,521,330	547,241	4,068,570
7		**Medical/Surgical other than primary care**																																
	26	In-state	2,373,477	133,824	2,507,301	17,385	1,341	18,726			-			-			-	5,354	-	5,354			-			-			-			-	2,396,216	135,165	2,531,381
	27	Out-of-state	429,183	432,394	861,577	442	1,815	2,257			-			-			-	-	-	-			-			-			-			-	429,625	434,208	863,834
	28	**Total Other Medical/Surgical (Lines 26 + 27)**	2,802,660	566,218	3,368,878	17,828	3,155	20,983	-	-	-	-	-	-	-	-	-	5,354	-	5,354	-	-	-	-	-	-	-	-	-	-	-	-	2,825,841	569,374	3,395,215
8		**All other payments to medical providers**																																
	29	**Total**	1,323,112	248,070	1,571,182	15,159	1,720	16,880			-			-			-	1,714	-	1,714			-			-			-			-	1,339,986	249,790	1,589,776

Field	Market Exhibit (For Comprehensive/Major Medical Line of Business)	1 Individual			2 Small Group			3 Large Group			4 Association			5 Trust			6 Federal Employee Health Benefit Plan			7 Other Health Market			8 Total (Across all markets)		
		RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
	Membership Data																								
	Number of Polices or Certificates	1	-	1	165	-	165	31	-	31			-			-			-			-	197	-	197
	Number of Covered Lives	1	-	1	702	140	842	3,233	597	3,830			-			-			-			-	3,936	737	4,673
1	Member Months	12	-	12	9,473	1,838	11,311	39,133	7,071	46,204			-			-			-			-	48,618	8,909	57,527
	Number of Polices or Certificates (**Plans with PD benefits**)	1	-	1	165	-	165	31	-	31	-	-	-	-	-	-	-	-	-	-	-	-	197	-	197
	Number of Covered Lives (**Plans with PD benefits**)	1	-	1	702	140	842	3,233	597	3,830	-	-	-	-	-	-	-	-	-	-	-	-	3,936	737	4,673
	Member Months (**Plans with PD benefits**)	12	-	12	9,473	1,838	11,311	39,133	7,071	46,204	-	-	-	-	-	-	-	-	-	-	-	-	48,618	8,909	57,527
	Premiums/Claims																								
2	Premium	2,874	-	2,874	3,658,257	690,328	4,348,585	15,721,439	2,863,457	18,584,896			-			-			-			-	19,382,569	3,553,785	22,936,354
	Claims/Medical Expenses	1,660	-	1,660	3,100,638	454,637	3,555,275	14,393,951	2,773,596	17,167,547			-			-			-			-	17,496,249	3,228,233	20,724,482
	Inpatient Facility																								
	Hospital																								
1	In-state	-	-	-	441,217	49,217	490,434	2,717,530	156,826	2,874,356			-			-			-			-	3,158,748	206,043	3,364,791
2	Out-of-state	-	-	-	52,816	12,154	64,969	487,911	347,844	835,755			-			-			-			-	540,726	359,998	900,724
3	Total (Lines 1 + 2)	-	-	-	494,033	61,371	555,404	3,205,441	504,670	3,710,111	-	-	-	-	-	-	-	-	-	-	-	-	3,699,474	566,041	4,265,515
	SNF																								
3 4	In-state	-	-	-	7,542	-	7,542	25,612	5,624	31,236			-			-			-			-	33,154	5,624	38,778
5	Out-of-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
6	Total (Lines 4 + 5)	-	-	-	7,542	-	7,542	25,612	5,624	31,236	-	-	-	-	-	-	-	-	-	-	-	-	33,154	5,624	38,778
	Other																								
7	In-state	-	-	-	-	-	-	1,167	-	1,167			-			-			-			-	1,167	-	1,167
8	Out-of-state	-	-	-	-	-	-	-	12,761	12,761			-			-			-			-	-	12,761	12,761
9	Total (Lines 7 + 8)	-	-	-	-	-	-	1,167	12,761	13,928	-	-	-	-	-	-	-	-	-	-	-	-	1,167	12,761	13,928
10	**Total Inpatient Facility (Lines 3 + 6 + 9)**	-	-	-	501,575	61,371	562,946	3,232,220	523,056	3,755,276	-	-	-	-	-	-	-	-	-	-	-	-	3,733,795	584,427	4,318,222
	Outpatient Facility																								
	Hospital																								
11	In-state	-	-	-	514,964	32,443	547,407	2,837,431	178,261	3,015,692			-			-			-			-	3,352,396	210,704	3,563,100
12	Out-of-state	-	-	-	117,047	54,151	171,198	200,349	484,800	685,149			-			-			-			-	317,396	538,951	856,347
13	Total (Lines 11 + 12)	-	-	-	632,011	86,594	718,605	3,037,780	663,061	3,700,842	-	-	-	-	-	-	-	-	-	-	-	-	3,669,791	749,655	4,419,447
	SNF																								
14	In-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
15	Out-of-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
4 16	Total (Lines 14 + 15)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Freestanding Ambulatory Care Facility																								
17	In-state	-	-	-	160,253	5,262	165,515	586,997	48,705	635,702			-			-			-			-	747,250	53,967	801,218
18	Out-of-state	-	-	-	42,588	11,594	54,182	126,262	90,297	216,558			-			-			-			-	168,850	101,890	270,740
19	Total (Lines 17 + 18)	-	-	-	202,841	16,856	219,698	713,259	139,002	852,260	-	-	-	-	-	-	-	-	-	-	-	-	916,100	155,858	1,071,958
	Other																								
20	In-state	1,420	-	1,420	109,081	7,179	116,260	617,925	10,551	628,476			-			-			-			-	728,426	17,731	746,156
21	Out-of-state	-	-	-	15,956	30,833	46,788	130,386	109,966	240,352			-			-			-			-	146,342	140,799	287,140
22	Total (Lines 20 + 21)	1,420	-	1,420	125,037	38,012	163,048	748,311	120,517	868,828	-	-	-	-	-	-	-	-	-	-	-	-	874,767	158,529	1,033,296
23	**Total Outpatient Facility (Lines 13 + 16 + 19 + 22)**	1,420	-	1,420	959,889	141,462	1,101,351	4,499,350	922,580	5,421,930	-	-	-	-	-	-	-	-	-	-	-	-	5,460,659	1,064,042	6,524,701

5		**Primary Care**																							
	24	**Total Primary Care**	-	-	-	236,566	66,277	302,843	878,870	153,449	1,032,319			-			-			-			-	1,115,436	219,726	1,335,162
6		**Pharmacy**																							
	25	**Total Pharmacy**			-	560,457	63,013	623,470	2,500,130	482,738	2,982,868			-			-			-			-	3,060,587	545,750	3,606,337
7		**Medical/Surgical other than primary care**																							
	26	In-state	107	-	107	500,447	25,883	526,330	1,872,922	107,942	1,980,864			-			-			-			-	2,373,477	133,824	2,507,301
	27	Out-of-state	-	-	-	100,752	54,851	155,604	328,431	377,542	705,973			-			-			-			-	429,183	432,394	861,577
	28	**Total Other Medical/Surgical (Lines 26 + 27)**	107	-	107	601,200	80,734	681,934	2,201,353	485,484	2,686,837	-	-	-	-	-	-	-	-	-	-	-	-	2,802,660	566,218	3,368,878
8		**All other payments to medical providers**																							
	29	**Total**	133	-	133	240,951	41,780	282,732	1,082,028	206,290	1,288,317			-			-			-			-	1,323,112	248,070	1,571,182

2012 Rate Review Process
Areas of Medical Expense Variation

Introductory Remarks

The stated goal of this exercise is to improve OHIC's understanding of the drivers of rising medical spending in Rhode Island by comparing the experience of the issuer's Rhode Island member base to a benchmark. For the purposes of this analysis, we have used our 2011 fully insured MA HMO experience as the benchmark. However, given the size of Tufts Health Plan's membership base in Rhode Island, the results of this comparative analysis will have limited credibility. Our relative costs by area of care have changed significantly in Rhode Island from year to year and are expected to continue to be volatile as our population in this market grows. Although we have commented on the probable causes of each variation listed, these fundamentally reflect a small, immature market compared to a much larger, more mature benchmark and should be interpreted with caution.

1. The top five areas of care, based on *per capita total dollar value* positive variation from the benchmark

Area of Care	Total Excess Spending	PMPM Excess Spending	Comments on Estimated Cause
INPATIENT ACUTE MED/SURG	$1,339,638	$23.29	Attributable to higher utilization (both admits and ALOS), rather than unit cost. High cost claimants identified as having a disproportionately large impact. The higher number of admits may be a consequence of lower than benchmark outpatient professional care.
PHARMACY - Rx MM	$717,042	$12.46	Attributable to higher utilization across tiers and therapeutic classes. Higher utilization driven by more members in RI having prescriptions filled than in the benchmark population, rather than a higher number of prescriptions per member.
OUTPATIENT LABORATORY	$558,538	$9.71	Capitation strategy applied in the benchmark population successfully contains cost.
OUTPATIENT INJECTIONS	$425,609	$7.40	Driven primarily by a difference in payment methodology between RI and the benchmark population. Injection claims in RI are reimbursed on a fee for service basis while in the benchmark population they are reimbursed on a fee for service basis or bundled into an outpatient surgery case payment. More than 50% of the higher RI utilization is associated with outpatient surgery claims, which would not be separately identified in the benchmark population.
OUTPATIENT EMERGENCY ROOM	$406,508	$7.07	Attributable primarily to a higher cost per emergency room encounter. This higher cost per encounter is driven less by higher unit cost in RI and more by the higher number of services delivered within an emergency room encounter compared to the benchmark.

2. The top five areas of care, based on *the percent of positive variation in per capita spending* from the benchmark

Area of Care	Percent of Positive Variation	Total Excess Spending	Comments on Estimated Cause
OUTPATIENT INJECTIONS	158%	$425,609	Driven primarily by a difference in payment methodology as described above.
FREE STANDING HIGH COST RADIOLOGY (MRI, PET, CT)	124%	$130,764	Higher utilization of allied health facilities, along with lower Outpatient Hospital High Cost Radiology utilization, reflects appropriate re-direction of care to lower cost providers.
OUTPATIENT LABORATORY	96%	$558,538	Capitation strategy applied in the benchmark population successfully contains cost.
INPATIENT OTHER	74%	$117,886	Driven by Mental Health/Substance Abuse services. Capitation strategy for inpatient Mental Health/Substance Abuse within the benchmark population effective at containing costs.
OUTPATIENT EMERGENCY ROOM	63%	$406,508	Attributable primarily to the number of services delivered within an emergency room encounter, as described above.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Provider Contracting Practices and Hospital Contracting Conditions Verification Questionnaire

Background

The Health Insurance Advisory Council (HIAC) to the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) has promulgated Affordability Standards for commercial health insurance issuers in Rhode Island.

Health plans will improve the affordability of health care in Rhode Island by focusing their efforts upon provider payment reform, beginning with primary care. Achievement of this goal will not add to overall medical spend in the short-term, and is expected to produce savings thereafter. Specific areas of focus in support of this goal are as follows:

1. Expand and improve the primary care infrastructure in the state—with limitations on ability to pass on cost in premiums
2. Spread Adoption of the "Chronic Care Model" Medical Home
3. Standardize electronic medical record (EMR) incentives
4. Work toward comprehensive payment reform across the delivery system

To support standard four, OHIC has previously issued six conditions for issuer contracts with hospitals in Rhode Island, to be implemented by issuers upon contract execution, renewal, or extension. These are as follows:

1. Utilize unit of service payment methodologies for both inpatient and hospital outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee for service.
2. Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index ("Index"), for all contractual and optional years covered by the contract
3. Provide the opportunity for hospitals to increase their total annual revenue for

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

commercially insured enrollment under the contract by at least additional two percentage points over the previous contract year by improving or attaining mutually agreed-to performance levels for no less than three nationally-accepted clinical quality, service quality or efficiency-based measures.

4. Include terms that define the parties' mutual obligations for greater administrative efficiencies
5. Include terms that promote and measure improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers.
6. Include terms that explicitly relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement.

The purpose of this questionnaire is to assess compliance with standard four of the Affordability Standards and to consider the responses in connection with OHIC's 2012 small and large employer group rate factor review process for commercial health insurance issuers in Rhode Island.

Directions

1. Please fill out all parts of questionnaire.
2. As no providers are identified and no financial details are solicited, none of this information will be considered proprietary or confidential. Should any information or document be considered confidential by the filer, the filer must request approval of the Health Insurance Commissioner. The request must identify the specific information or document (or portion thereof) which the filer considers confidential, accompanied by a factual and legal analysis supporting the request.
3. Questionnaire responses must be verified by filing those portions of each hospital contract which support the survey response. An index or other method of reference must be included to identify which hospital contract documentation relates to each survey response. Any contract excerpts provided will be summarized for review.
4. Please contact OHIC with any questions.

State of Rhode Island Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920-4407
(401) 462-9640
(401) 462-9645 (Fax)
www.ohic.ri.gov
THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

General comment:

Tufts Health Plan has a long standing commitment to investment in payer-provider incentive alignment, and we maintain hospital and physician incentive programs that apply to the vast majority of our network providers. As a relatively new entrant into the RI market, we are at an early stage of incorporating incentive mechanisms into our RI provider contracts. Provider incentive will be a key component of our contracting strategy as we grow our presence in the state of RI.

Tufts Health Plan requests that the information provided in response to this survey be deemed to constitute "trade secrets" within the meaning of the term in section 38-2-2(4)(i)(B) of the Rhode Island General Laws. We have included a footer stating "THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION".

Finally, due to the questionable reliability of certain information provided in our responses, which is explained in further detail below, it is Tufts Health Plan's expectation and understanding that the information provided in this Provider Survey will not be used or considered in OHIC's review of Tufts Health Plan's rates.

Part 1. Hospital Inpatient Services

- **Please fill out one row in the chart below for <u>each</u> general service institution (no specialty care, no rehab) with whom you contract in RI.**
- **Institution means hospital system if all contractual terms other than $ amounts apply identically across all inpatient facilities in the contract.**
- **Incentives refer to activities or measures resulting in additional payments by the insurer.**

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments

[1] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[2] Attach analysis and relevant documentation from contracts to demonstrate compliance status.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
1	3 Years	X DRG X Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	No	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [3]	__ admission reductions __ day reductions __ process/structural changes (e.g. discharge practices) __Others (please specify)	N/A (Contract has not been renegotiated)	
2	3 Years	x DRG x Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.5~1.0%____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
3	3 Years	__DRG __Per Diem x % of Charges __ Bundled Services	No	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

[3] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
		__ Capitation or other budgeting __Others (please specify)		incentive payments. 0.1~0.5%			
4	2 Years	__DRG x Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
5	3 Years	__DRG __Per Diem x % of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	No	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
6	3 Years	__DRG __Per Diem x % of Charges __ Bundled	No	No If yes - % of total payments for inpatient services in CY	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
		Services __ Capitation or other budgeting __Others (please specify)		2011 spent on quality incentive payments. _____			
7	1 Year	__DRG _x_Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. ____ 0-2%	_X_ admission reductions _X_ day reductions __Others (please specify)	Yes, please see attached	
8	3 Years	__DRG _x_Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

Additional Questions for Hospital Inpatient Services

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

1. List the five most common areas of quality and service incentives in your company's inpatient contracts:
(These measures apply to our hospital contracts that combine inpatient and outpatient services.)
   i. Joint Commission measures (e.g., AMI, CHF, pneumonia)
   ii. Leapfrog measures (e.g., CPOD, ICU staffing)
   iii. Prevention of "Never Events"
   iv. Surgical infection rates
   v. Readmission rates
2. Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2011 spent on quality incentive payments. 0.1~1%

3. Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2011 paid through units of service based on efficient resource use (i.e DRG, Capitation, Bundled Service or partial/global budgeting): <5%

4. Estimated Payments in first six months of CY 2011 for Inpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: See comment (add comments or caveats)

   For inpatient services Tufts Health Plan does not currently have the technical capability to benchmark to Medicare IPPS reimbursement. Conducting such analysis would require incremental time, resources and technical capabilities. Benchmarking Tufts Health Plan inpatient payments to Medicare IPPS may yield volatile and potentially unreliable results due to a) differences in reimbursement methodology (Tufts Health Plan reimburses the majority of inpatient claims on either a Per Diem or Percent of Charge basis); b) our relatively small volume of business in Rhode Island; c) mix of services; and d) chargemaster levels to some of the hospitals in Rhode Island. Additionally, it is our belief that a Medicare comparison for some hospitals that perform very specific services, like Obstetrics, will not result in a comparison that is useful and may lead to unintended and/or misinterpreted conclusions.

Other Comments on Quality/Efficiency Incentives in Hospital Inpatient Contracting:

Part 2. Hospital Outpatient Services

- **Please fill out one row in the chart below for each general service institution (no specialty care, no rehab) with whom you contract in RI.**
- **Institution means hospital system if all contractual terms other than dollar amounts apply identically across all inpatient facilities in the contract.**
- **Outpatient Services include any services not involving an admission and covered under the contract with the institution.**

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[4]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - %of total payments for inpatient services in CY 2011 spent on quality incentive payments. [5]	__ Visit/Volume Reduction __ Others (please specify)	
2	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.5~1.0%____	__ Visit/Volume Reduction __ Others (please specify)	
3	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.1~0.5%	__ Visit/Volume Reduction __ Others (please specify)	
4	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality	__ Visit/Volume Reduction __ Others (please specify)	

[4] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[5] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[4]?	Utilization Incentives in Contract: (check all that apply)	Comments
		incentive payments. _____		
5	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
6	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
7	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
8	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	

Additional Questions for Hospital Outpatient Services

1. List the five most common areas of quality and service incentives in your company's hospital outpatient contracts:

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

(These measures apply to our hospital contracts that combine inpatient and outpatient services.)

i. Joint Commission measures (e.g., AMI, CHF, pneumonia)
ii. Leapfrog measures (e.g., CPOD, ICU staffing)
iii. Prevention of "Never Events"
iv. Surgical infection rates
v. Readmission rates

2. Percent of total payments to RI Hospitals for outpatient services in CY 2011 spent on quality incentive payments. 0.1~1%

3. Percent of total payments to RI Hospitals for outpatient services in CY 2011 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): n/a

4. Estimated Payments in first six months of CY 2011 for Outpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: 222% (i.e. 122% over Medicare Reimbursement) (add comments or caveats)

   For Outpatient Services, Tufts Health Plan has the technical capabilities to perform the required benchmarking analysis to Medicare; however, we have concerns about the confidence level in the accuracy of the supplied benchmark. Our concerns are due to a) the allowed reimbursement at a claim level was compared to fee information obtained from OPPS and CMS ancillary schedules such as Clinical Lab, DME etc.; b) we are not able to reprocess our claims through an OPPS Grouper and were limited to a line level reprice based on OPPS/Ancillary fees which means that exact Medicare reimbursement can only be approximated; c) Procedures that do not have a fee on OPPS/Ancillary schedules, or are billed in a different manner to Medicare (e.g., observation) were dropped from the analysis.

   Additionally, Tufts Health Plan has concerns that the results may be skewed due to a few high-volume hospitals and the large number of providers reimbursed on a percent of charges basis – factors that may distort the data due to particular mix of services and chargemaster levels of PAF providers. Based on the concerns listed above it is our belief that a Medicare comparison might not result in a benchmark that is useful and could lead to unintended and/or misinterpreted conclusions that if made public could impact certain contract negotiations by putting upward pressure on unit costs.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Other Comments on Quality/Efficiency Incentives in Hospital Outpatient Contracting:

Part 3: Professional Groups

- **"Professional Groups" is defined as non institutional/non facility groups with a valid contract and a single tax id number.**
- **Please provide information for the top 10 groups (measured by $ paid in 2011), filling in one row per group (10 rows in the table total).**

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	Multi-specialty	x Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [7] _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services _ Others (please specify)	
2	Multi-specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
3	Multi-specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code	No If yes - % of total payments for inpatient services in CY 2011 spent	__Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care	

[6] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[7] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
		__ Full/ Partial Capitation __Other (please specify)	on quality incentive payments. _____	__ use of pharmacy services __ Others (please specify)	
4	Sub - Specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
5	Primary Care	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
6	Primary Care	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0~5%	x Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care x use of pharmacy services x Others (please specify)	Quality/Member Satisfaction
7	Sub - Specialty	_ X _ Procedure-based methodology – using CPT, plan,	No	__ Visit/Volume Reduction __use of ancillary/referred services	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
		provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments.	__ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
8	Sub - Specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
9	Multi-specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
10	Multi-specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Additional Questions for Professional Groups

1. List the five most common areas of quality and service incentives in your company's professional group contracts:
   i. HEDIS (diabetes, breast cancer screening, colonoscopy, etc.)
   ii. HCHAPS
   iii. EMR adoption
   iv. Inpatient and ER use
   v. Rx Management
2. Percent of total payments to these ten professional groups in CY 2011 spent on quality incentive payments. ___<1%_____

3. Percent of total payments to these ten professional groups in CY 2011 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): ___n/a_____

4. Estimated Payments in first six months of CY 2011 for Professional Group Services as % of what Medicare would have paid for similar set. of services: 122% (i.e. 22% over Medicare Reimbursement) (add comments or caveats)

   The analysis was conducted using a claim line level comparison between allowed reimbursement and Medicare fee information obtained from RBRVS tables as well as Medicare ancillary schedules such as clinical lab, DME etc. Anesthesia services were also included. Procedures that Medicare does not reimburse but supplies RVU information for, such as preventive medicine and consults codes, are included at the RVU level rate for the Medicare comparison. Claims lines that do not have RBRVS/Ancillary schedule information were dropped from the analysis.

   Additionally, Tufts Health Plan has concerns that the results may be skewed due to particular mix of services for providers. Based on the concerns listed above it is our belief that a Medicare comparison might not result in a benchmark that is useful and could lead to unintended and/or misinterpreted conclusions that if made public could impact certain contract negotiations by putting upward pressure on unit costs.

Other Comments on Quality/Efficiency Incentives in Professional Group Contracting:

Selected Contract Sections Showing Compliance To OHIC Conditions

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Effective for dates of service on or after January 1, 2011

Office of the Health Insurance Commissioner Conditions

Pay-For-Performance: **[Redacted]** is available for the Hospital to earn based upon quality and/or efficiency measures **[redacted]**.

Case Rates: In the event **[redacted]** parties agree to meet to discuss the potential to transition to efficiency based payment methodologies (e.g., DRG, APC) in a manner that **[redacted]**.

Administrative Efficiency: Tufts Health Plan agrees to assign a Contract Specialist to provide ongoing contract related support through the term of the agreement to help mitigate contract related issues.

The Hospital agrees to work with and communicate issues to the Contract Specialist on an ongoing basis and work in good faith to resolve contract related issues in a timely manner.

Communication: During calendar year 2011 parties agree to formalize clinical communication that promotes and measures improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers.

Public Release of Contract Terms: Parties agree to allow the public release of terms outlined in this agreement if compelled by State regulatory authorities.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

1. Please provide an excel spreadsheet in the following format, detailing the 2011 actual and 2013 requested small and large group administrative costs pmpm, allocated among the NAIC- financial statement administrative cost categories. Please explain any significant changes from the financial filing for 2011 (increases/decreases of more than five percent in a particular category).

RI Insured HMO	2011 Actual (from filed financial statements)		2013 Proposed		% Change	
	Small Group	Large Group	Small Group	Large Group	Small Group	Large Group
Total Estimated Member Months	4,509	18,246	4,480	19,600	-0.6%	7.4%
Total Estimated Premiums ($pmpm)	$378.21	$397.92	$420.71	$442.55	11.2%	11.2%
Total General Administrative Expense	$41.82	$41.20	$47.08	$44.89	12.6%	9.0%
Total Cost Containment Expense	$10.43	$9.64	$10.17	$10.17	-2.5%	5.5%
Total Other Claim Adjustment Expense ($pmpm)	$7.99	$7.38	$7.79	$7.79	-2.5%	5.5%
Breakdown of General Administrative Expense ($pmpm)						
a. Payroll and benefits	$2.94	$2.72	$2.87	$2.87	-2.5%	5.5%
b. Outsourced Services (EDP, claims etc.)	$0.09	$0.09	$0.09	$0.09	-2.5%	5.5%
c. Auditing and consulting	$8.02	$7.42	$7.82	$7.82	-2.5%	5.5%
d. Commissions	$13.59	$14.62	$15.35	$13.15	12.9%	-10.0%
e. Marketing and Advertising	$1.76	$1.63	$1.72	$1.72	-2.5%	5.5%
f. Legal Expenses	$0.17	$0.16	$0.16	$0.16	-2.5%	5.5%
g. Taxes, Licenses and Fees	$7.56	$7.96	$11.99	$11.99	58.5%	50.6%
h. Reimbursements by Uninsured Plans	$0.00	$0.00	$0.00	$0.00	0.0%	0.0%
i. Other Admin Expenses	$7.68	$6.62	$7.09	$7.09	-7.7%	7.1%

Notes

1. The expense in any given administrative category may vary from year to year due to the small size of Tufts Health Plan's HMO block of business in Rhode Island. In aggregate, however, total admin has increased less than about 3% per year.

2. Please also provide an excel spreadsheet in the following format; detailing actual calendar year 2007-2011 fully insured commercial administrative costs, in accordance with the following table. This should be consistent with the annual statement filings to OHIC for administrative costs, providing additional detail on the components of administrative costs using the categories defined by NAIC financial statement and as allocated to commercially insured business only. Specifically, the information provided should agree with the "Exhibit of Premiums, Enrollment and Utilization" and the "Analysis of Operations by Line of Business" schedules included in the Annual Statements on file with OHIC. Where there are variance, a reconciliation and explanation should be provided.

Fully Insured Commercial Administrative Cost History

RI Insured HMO	2007	2008	2009	2010	2011
Total Premiums			1,212,134	6,544,977	8,965,746
Total General Administrative Expense			192,865	732,653	940,237
General Admin Exp. Ratio			15.9%	11.2%	10.5%
Total Fully Insured Member Months			3,878	18,547	22,755
General Administrative Expense ($pmpm)			$49.73	$39.50	$41.32
Breakdown of General Administrative Expense ($pmpm)					
a. Payroll and benefits			$3.37	$2.49	$2.76
b. Outsourced Services (EDP, claims etc.)			$0.01	$0.01	$0.09
c. Auditing and consulting			$5.92	$4.93	$7.54
d. Commissions			$11.74	$16.10	$14.41
e. Marketing and Advertising			$2.52	$1.72	$1.66
f. Legal Expenses			$0.08	$0.11	$0.16
g. Taxes, Licenses and Fees			$6.25	$7.06	$7.88
h. Reimbursements by Uninsured Plans			$0.00	$0.00	$0.00
i. Other Admin Expenses			$19.85	$7.03	$6.83
Cost Containment Expense			20,663	158,478	222,967
Other Claim Adjustment Expense			27,194	151,819	170,707
Total Self Insured Member Months for all Affiliated Companies doing business in RI			113,694	0	662

Notes:

1. Total premiums for 2010 differ from the aggregate amount submitted in last year's filing, but are consistent with the individual small and large group figures submitted last year.

RI Insured HMO

3. At the request of OHIC's Health Insurance Advisory Council, please provide brief answers to the following questions

- **In general and net of new taxes and fees, why should the rate of increase in Health Plan administrative costs exceed the general inflation rate?**

  Administrative expenses in total in a given year are adjusted for inflation, membership growth or loss and increases or decreases in corporate projects, which are often driven by regulatory requirements and government mandates. As a general practice, to set administrative expense targets for the annual financial plan, fixed administrative costs are grown at an inflationary rate. Variable administrative costs are then developed by applying inflation to the variable pmpm rate and then multiplying the inflated pmpm rate by planned member months. While those are the initial steps to develop targets, each administrative function is reviewed in detail to identify potential administrative cost savings and targets are adjusted accordingly.

- **What percentage of administrative costs does your organization consider fixed for the next five years? Provide detail by expense categories.**

  For the total company, we currently consider 58% of our costs fixed as follows:

Fixed Administrative Costs by Category:	
Network Management	2%
Sales and Marketing	4%
Clinical Services	5%
Operations	5%
IT & Business Effectiveness	8%
Corporate Projects	14%
Fixed Overhead and Other	20%
Total Fixed Administrative Expenses	58%

- **What administrative services are used by fully insured members that are not used by self-insured clients (e.g. broker commissions) and what are the estimated total costs ($pmpm) for those services?**

  Administrative costs for fully insured membership include expenses associated with medical cost containment ($9.80 pmpm), whereas in most cases self-insured clients bear these costs directly. Broker commissions ($14.41 pmpm) are also not applicable to most self-insured clients.

- **What does your plan use as its pmpm benchmarks or price points for commercial insurance administrative costs and why?**

We periodically participate in the benchmarking survey used to develop the *Sherlock Expense Evaluation Reports* (SEER) which are viewed as the definitive benchmarks for the functional areas of health plan administration. The Sherlock Expense Evaluation Reports (SEER) supply comprehensive and highly granular financial and operational metrics.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Health System Improvements Survey

The State of Rhode Island Office of the Health Insurance Commissioner Regulation 2 lists standards to be used by the Health Insurance Commissioner (Commissioner) for the assessment of the conduct of commercial health insurance issuers in Rhode Island for their efforts aimed at improving the efficiency and quality of health care delivery and increasing access to health care services. The standards include the following issuer activities:

1. Directing resources, including financial contributions, toward system-wide improvements in the state's health care system related to quality, access and efficiency, including providing support to local collaboratives, organizations, and initiatives that promote these three goals

2. Participating in the development and implementation of public policy issues related to health

To assist the Commissioner in this assessment, as part of the 2012 small and large employer group rate factor review process for commercial health insurance issuers in Rhode Island, please itemize and quantify your organization's contributions of finances and other material assets to these efforts in Rhode Island in calendar year 2011 in the following table.[1]

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
Funding	Grants provided by the Tufts Health Plan Foundation and Community Relations to the following RI organizations to support wellness and safety initiatives • **Best Buddies International** *Best Buddies Intergenerational College Project* Grant Amount: $20,000 • **Mount St. Rita Health Centre** *Blessings in a Back Pack* Grant Amount: $5,000 • **Bethany Home of Rhode Island Inc.**	**$515,724**

[1] The contributions can be to any entity other than a provider to improve medical and prevention services for all Rhode Islanders and to promote a coherent, integrated, and efficient statewide health care system.

State of Rhode Island Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920-4407
(401) 462-9640
(401) 462-9645 (Fax)
www.ohic.ri.gov

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
	Bethany Home Cares Grant Amount: $43,036 • **Homefront Health Care** *HIP-SAFE (Homefront Intervention to Prevent Slips & Falls in Elders)* Grant Amount: $59,438 • **Rhode Island Free Clinic Inc.** *Healthy Lifestyles for Today and Tomorrow* Grant Amount: $60,000 • **The Providence Center** *InShape Seniors* Grant Amount: $42,000 • **Ocean State Center for Independent Living (OSCIL)** *Home Sweet Accessible Home* Grant Amount: $40,000 • **Westbay Community Action Inc.** *Elder Safety* Grant Amount: $42,000 • **Rhode Island Quality Institute** *Health Information Exchange Support* Grant Amount: $25,000 • **EMR Payments** $179,250	

Participation in RI initiatives, programs and organizations	The goals of these programs, initiatives and organizations is to improve quality and/or transform primary care in the state:
	• CSI/Beacon (Project director, project manager, and nurse case manager support) $38,329
	• Value of Resource Time in Various Programs (Estimate of $30,000 for 0.2 FTE for 2011)
	  ○ RI DOH Medical Director meetings
	  ○ RI Quality Partners Safe Transitions
	  ○ RI Senate Commission on Hospital Payment Reform
	  ○ RIQI Board of Directors
	  ○ RI CSI Beacon Executive Committee
		$68,329

Thank you for your cooperation.

Tufts Associated Health Maintenance Organizations, Inc.

Large Group Rate Filing -- Effective Date January 1, 201

Part 1. Historical Information

Experience Period for Developing Rates	
From	To
01/01/2009	12/31/2011

Utilization/Experience Data by Quarter (Last 12 Available Quarters)

Quarter	End Date	IP Days	Member Months	Earned Premium	Incurred Claims Total	Incurred Claims IP	Incurred Claims OP	Incurred Claims Primary Care	Incurred Claims Other M/S	Incurred Claims Rx	Loss Ratio	Quality Improvement Expense*	Other Cost Containment Expense*	Other Claim Adjustment Expense*	Other Operating Expense*	Investment Income Credit	Commissions	Contribution to Reserves
1 (Oldest)	03/31/2009	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	06/30/2009	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	09/30/2009	10	535	$184,026	$192,099	$35,287	$46,636	$9,661	$54,252	$46,262	106.3%	$3,460	$1,792	$3,129	$17,887	N/A	$5,392	($39,735)
4	12/31/2009	12	1,447	$430,624	$502,287	$47,728	$151,561	$28,866	$196,898	$77,234	118.8%	$9,359	$4,848	$8,464	$48,380	N/A	$14,583	($157,297)
5	03/31/2010	97	2,467	$864,452	$1,023,105	$326,462	$209,880	$42,867	$295,045	$148,851	120.1%	$15,527	$7,277	$12,705	$61,151	N/A	$36,360	($291,672)
6	06/30/2010	99	3,261	$1,167,742	$1,043,432	$207,698	$275,710	$61,342	$316,059	$182,623	91.1%	$20,524	$9,619	$16,793	$80,832	N/A	$48,062	($51,521)
7	09/30/2010	30	3,438	$1,261,070	$986,927	$196,908	$251,210	$63,976	$280,563	$194,270	80.0%	$21,638	$10,141	$17,705	$85,220	N/A	$50,671	$88,769
8	12/31/2010	61	3,539	$1,346,188	$1,045,547	$221,223	$241,432	$84,149	$298,584	$200,160	79.3%	$22,274	$10,439	$18,225	$87,723	N/A	$52,160	$109,820
9	03/31/2011	131	3,964	$1,550,685	$1,260,828	$275,912	$318,962	$84,165	$353,698	$228,092	82.9%	$24,785	$23,748	$23,614	$101,776	N/A	$58,303	$57,630
10	06/30/2011	178	4,476	$1,783,022	$1,915,167	$487,008	$439,723	$97,117	$599,106	$292,213	109.0%	$27,986	$26,816	$26,664	$114,922	N/A	$65,833	($394,366)
11	09/30/2011	137	4,793	$1,894,713	$1,800,129	$422,156	$491,354	$114,320	$476,856	$295,443	96.6%	$29,968	$28,715	$28,552	$123,061	N/A	$70,496	($186,208)
12	12/31/2011	123	4,900	$1,971,233	$2,176,833	$705,730	$479,709	$120,936	$562,108	$308,351	112.0%	$30,637	$29,356	$29,190	$125,808	N/A	$72,069	($492,661)

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3- Analysis of Expenses and/or to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1

If any of the historical information reported is different from that period as reported in the prior rate filing, please provide a reconciliation and explanation showing the amount of each element of difference.

Notes:
1. The Other Operating Expenses shown above include taxes, licenses and fees, which were excluded in previous filings for the same time periods
2. Primary care claims definition has been revised to match the Primary Care Spend report
3. Expenses such as network access fee, COB and claims interest are moved from Other M/S claims to administrative expenses according to NAIC definition
4. Claims Total differences from the previous filings for the same time periods are due to updated IBNR factors that reflect more up to date claims payment, as well as the revision to the Other M/S claims definition
5. Loss ratio is calculated as (Incurred Claims Total + Quality Improvement Expense) / Earned Premium

Part 2. Prospective Information

A. 2013 Trend Factors for Projection Purposes (Annualized)

	IP	OP	Primary Care	Other M/S	Rx	Weighted Total
Total	5.2%	6.7%	5.4%	4.7%	4.7%	5.4%
Price Only	3.6%	3.4%	3.3%	1.8%	0.8%	2.6%
Utilization	1.5%	3.2%	2.0%	2.9%	3.9%	2.8%
Other**						
Other**						
Other**						
Weights	20.4%	26.5%	9.4%	26.3%	17.4%	100%

** All elements should add or compound to the total. If anything is to be reported as "Other" please provide a description.

2012 Trend Factors for Projection Purposes (Annualized)

	IP	OP	Primary Care	Other M/S	Autism Mandate	Rx	Weighted Total
Total	5.9%	7.6%	6.4%	4.8%	0.2%	0.3%	5.3%
Price Only	3.6%	3.7%	4.1%	1.3%		-3.6%	1.9%
Utilization	2.2%	3.8%	2.2%	3.5%		4.0%	3.3%
Other**							
Other**							
Other**							
Weights	20.2%	24.7%	8.4%	29.3%		17.4%	100%

** All elements should add or compound to the total. If anything is to be reported as "Other" please provide a description.

B. The following items for the period to which the rate filing applies, by quarter:

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %
1	01/01/2013	6.1%	86.4%	0.0%	1.6%	1.4%	1.4%	4.2%	3.0%	0.0%	2.0%
2	04/01/2013	5.8%	86.4%	0.0%	1.6%	1.4%	1.4%	4.2%	3.0%	0.0%	2.0%

3	07/01/2013	5.9%	86.4%	0.0%	1.6%	1.4%	1.4%	4.2%	3.0%	0.0%	2.0%
4	10/01/2013	6.1%	86.4%	0.0%	1.6%	1.4%	1.4%	4.2%	3.0%	0.0%	2.0%
Weighted Average		6.0%	86.4%	0.0%	1.6%	1.4%	1.4%	4.2%	3.0%	0.0%	2.0%

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %
1	01/01/2012	3.4%	87.0%	0.0%	0.9%	0.7%	1.3%	5.1%	3.0%	0.0%	2.0%
2	04/01/2012	3.0%	87.0%	0.0%	0.9%	0.7%	1.3%	5.1%	3.0%	0.0%	2.0%
3	07/01/2012	4.0%	87.0%	0.0%	0.9%	0.7%	1.3%	5.1%	3.0%	0.0%	2.0%
4	10/01/2012	6.6%	87.0%	0.0%	0.9%	0.7%	1.3%	5.1%	3.0%	0.0%	2.0%
Weighted Average		4.2%	87.0%	0.0%	0.9%	0.7%	1.3%	5.1%	3.0%	0.0%	2.0%

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3 - Analysis of Expenses and to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1
The sum of the expenses, commissions, contributions to reserves, investment income credit, taxes and the medical loss ratio should be 100%.

C. Average Rate Increase Components

The following items should reconcile to the Weighted Average Percent Rate Increase for the year:

	Price	Utilization, Mix	Total
Hospital Inpatient Price	0.6%	0.3%	0.9%
Hospital Outpatient	0.8%	0.7%	1.5%
Primary Care	0.3%	0.2%	0.4%
Med/Surg Other Than Primary Care	0.4%	0.7%	1.1%
Pharmacy	0.1%	0.6%	0.7%
Administrative Expense (Aggregated)			0.6%
Contribution to Reserves			0.0%
Taxes and Assessments			0.1%
Legally Mandated Changes			0.0%
Prior Period Adjustment (+/-)			0.6%
Total			6.0%

Note:
1. Due to the lack of credible experience, manual rates are developed by trending forward prior base rates to reflect trend changes. Therefore, depending on the timing of trend change, rate increases may be different from trend increase. The difference is reflected as Prior Period Adjustment above.

Part 3. Retrospective Reconciliation of Experience with Filed Factors

	Filed Data[1]					PMPM Increase[2]		Standard Plan PMPM[3]		Standard Plan Increase[4]		Approved		Loss Ratio	
Year	Member Months	Earned Premium	Incurred Claims Total	Premium PMPM	Claims PMPM	Premium	Claims	Premium	Claims	Premium	Claims	Trend Increase%	Contrib to Reserves%	Actual%	Filed%
2009	1,982	614,650	707,206	$310.12	$356.81			251.04	406.66			9.7%	0%	115.1%	87.0%
2010	12,705	4,639,452	4,178,975	$365.17	$328.92	17.8%	-7.8%	256.39	236.35	2.1%	-41.9%	9.3%	0%	90.1%	87.0%
2011	18,133	7,199,652	7,266,335	$397.05	$400.72	8.7%	21.8%	313.93	293.50	22.4%	24.2%	9.2%	0%	100.9%	87.9%

[1] Corresponds to historical Information data in Part 1 above
[2] Percent increase compared to prior year
[3] For most commonly held plan of benefits in 2010 and for the same plan of benefits in 2011
[4] Percent increase compared to prior year

Note:
1. Filed loss ratio for CY 2011 is the sum of the expected pure medical cost ratio and expected quality improvement expenses % in 2011 rate factor filing

Rhode Island Health Statement Supplement

Cover Sheet

Company Name	**Tufts Associated Health Maintenance Organizations & Tufts Insurance Company**		
Enter NAIC#	**95688 & 60177**	**Reporting Year**	**2011**
Enter DBR registration # (TPAs)			

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Office of the Health Insurance Commissioner
1511 Pontiac Ave, Building #69 first floor
Cranston, RI 02920
(401) 462-9517
(401) 462-9645 (fax)
HealthInsInquiry@ohic.ri.gov

Line of Business Exhibit

Field			1 Comprehensive/Major medical			2 ASO/TPA			3 Stop loss/ Excess loss/Reinsurance			4 Medicare Part C			5 Medicare Part D			6 Medicare Supplement Policies			7 Medicaid/Other public			8 Student blanket			9 Dental Only			10 Other Medical Non-Comprehensive			11 Total (Across all lines of business)		
			RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
1		**Membership Data**																																
		Number of Polices or Certificates	197	-	197	1	-	1			-			-	91		91	3	-	3			-			-			-			-	292	-	292
		Number of Covered Lives	3,936	737	4,673	299	29	328			-			-	91		91	5	-	5			-			-			-			-	4,331	766	5,097
		Member Months	48,618	8,909	57,527	603	59	662			-			-	1,062		1,062	60	-	60			-			-			-			-	50,343	8,968	59,311
		Number of Polices or Certificates (**Plans with PD benefits**)	197	-	197	1	-	1	-	-	-	-	-	-	91	-	91	3	-	3	-	-	-	-	-	-	-	-	-	-	-	-	292	-	292
		Number of Covered Lives (**Plans with PD benefits**)	3,936	737	4,673	299	29	328	-	-	-	-	-	-	91	-	91	5	-	5	-	-	-	-	-	-	-	-	-	-	-	-	4,331	766	5,097
		Member Months (**Plans with PD benefits**)	48,618	8,909	57,527	603	59	662	-	-	-	-	-	-	1,062	-	1,062	60	-	60	-	-	-	-	-	-	-	-	-	-	-	-	50,343	8,968	59,311
2		**Premiums/Claims**																																
		Premium	19,382,569	3,553,785	22,936,354	162,614	18,088	180,702			-			-	146,221		146,221	23,160	-	23,160			-			-			-			-	19,714,564	3,571,873	23,286,437
		Claims/Medical Expenses	17,496,249	3,228,233	20,724,482	139,151	15,072	154,222			-			-	405,690		405,690	20,052	-	20,052			-			-			-			-	18,061,142	3,243,305	21,304,446
3		**Inpatient Facility**																																
		Hospital																																
	1	In-state	3,158,748	206,043	3,364,791	17,550	-	17,550			-			-			-	-	-	-			-			-			-			-	3,176,298	206,043	3,382,341
	2	Out-of-state	540,726	359,998	900,724	-	-	-			-			-			-	-	-	-			-			-			-			-	540,726	359,998	900,724
	3	Total (Lines 1 + 2)	3,699,474	566,041	4,265,515	17,550	-	17,550	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3,717,024	566,041	4,283,065
		SNF																																
	4	In-state	33,154	5,624	38,778	-	-	-			-			-			-	-	-	-			-			-			-			-	33,154	5,624	38,778
	5	Out-of-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	6	Total (Lines 4 + 5)	33,154	5,624	38,778	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	33,154	5,624	38,778
		Other																																
	7	In-state	1,167	-	1,167	-	-	-			-			-			-	-	-	-			-			-			-			-	1,167	-	1,167
	8	Out-of-state	-	12,761	12,761	-	-	-			-			-			-	-	-	-			-			-			-			-	-	12,761	12,761
	9	Total (Lines 7 + 8)	1,167	12,761	13,928	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,167	12,761	13,928
	10	**Total Inpatient Facility (Lines 3 + 6 + 9)**	3,733,795	584,427	4,318,222	17,550	-	17,550	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3,751,345	584,427	4,335,772
4		**Outpatient Facility**																																
		Hospital																																
	11	In-state	3,352,396	210,704	3,563,100	22,675	916	23,591			-			-			-	1,633	-	1,633			-			-			-			-	3,376,704	211,620	3,588,324
	12	Out-of-state	317,396	538,951	856,347	1,088	1,834	2,922			-			-			-	-	-	-			-			-			-			-	318,484	540,785	859,269
	13	Total (Lines 11 + 12)	3,669,791	749,655	4,419,447	23,763	2,749	26,512	-	-	-	-	-	-	-	-	-	1,633	-	1,633	-	-	-	-	-	-	-	-	-	-	-	-	3,695,188	752,404	4,447,593
		SNF																																
	14	In-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	15	Out-of-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	16	Total (Lines 14 + 15)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
		Freestanding Ambulatory Care Facility																																
	17	In-state	747,250	53,967	801,218	1,893	-	1,893			-			-			-	-	-	-			-			-			-			-	749,143	53,967	803,110
	18	Out-of-state	168,850	101,890	270,740	-	4,631	4,631			-			-			-	-	-	-			-			-			-			-	168,850	106,521	275,371
	19	Total (Lines 17 +18)	916,100	155,858	1,071,958	1,893	4,631	6,524	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	917,993	160,489	1,078,482
		Other																																
	20	In-state	728,426	17,731	746,156	2,074	115	2,189			-			-			-	310	-	310			-			-			-			-	730,809	17,845	748,655
	21	Out-of-state	146,342	140,799	287,140	945	369	1,314			-			-			-	47	-	47			-			-			-			-	147,334	141,167	288,501
	22	Total (Lines 20 + 21)	874,767	158,529	1,033,296	3,019	484	3,503	-	-	-	-	-	-	-	-	-	357	-	357	-	-	-	-	-	-	-	-	-	-	-	-	878,143	159,013	1,037,156
	23	**Total Outpatient Facility (Lines 13 + 16 + 19 + 22)**	5,460,659	1,064,042	6,524,701	28,676	7,864	36,539	-	-	-	-	-	-	-	-	-	1,990	-	1,990	-	-	-	-	-	-	-	-	-	-	-	-	5,491,325	1,071,906	6,563,231
5		**Primary Care**																																
	24	**Total Primary Care**	1,115,436	219,726	1,335,162	15,201	842	16,043			-			-			-	679	-	679			-			-			-			-	1,131,316	220,567	1,351,883
6		**Pharmacy**																																
	25	**Total Pharmacy**	3,060,587	545,750	3,606,337	44,737	1,491	46,227			-			-	405,690		405,690	10,316	-	10,316			-			-			-			-	3,521,330	547,241	4,068,570
7		**Medical/Surgical other than primary care**																																
	26	In-state	2,373,477	133,824	2,507,301	17,385	1,341	18,726			-			-			-	5,354	-	5,354			-			-			-			-	2,396,216	135,165	2,531,381
	27	Out-of-state	429,183	432,394	861,577	442	1,815	2,257			-			-			-	-	-	-			-			-			-			-	429,625	434,208	863,834
	28	**Total Other Medical/Surgical (Lines 26 + 27)**	2,802,660	566,218	3,368,878	17,828	3,155	20,983	-	-	-	-	-	-	-	-	-	5,354	-	5,354	-	-	-	-	-	-	-	-	-	-	-	-	2,825,841	569,374	3,395,215
8		**All other payments to medical providers**																																
	29	**Total**	1,323,112	248,070	1,571,182	15,159	1,720	16,880			-			-			-	1,714	-	1,714			-			-			-			-	1,339,986	249,790	1,589,776

Field	Market Exhibit (For Comprehensive/Major Medical Line of Business)	1 Individual			2 Small Group			3 Large Group			4 Association			5 Trust			6 Federal Employee Health Benefit Plan			7 Other Health Market			8 Total (Across all markets)		
		RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
	Membership Data																								
	Number of Polices or Certificates	1	-	1	165	-	165	31	-	31			-			-			-			-	197	-	197
	Number of Covered Lives	1	-	1	702	140	842	3,233	597	3,830			-			-			-			-	3,936	737	4,673
1	Member Months	12	-	12	9,473	1,838	11,311	39,133	7,071	46,204			-			-			-			-	48,618	8,909	57,527
	Number of Polices or Certificates (**Plans with PD benefits**)	1	-	1	165	-	165	31	-	31	-	-	-	-	-	-	-	-	-	-	-	-	197	-	197
	Number of Covered Lives (**Plans with PD benefits**)	1	-	1	702	140	842	3,233	597	3,830	-	-	-	-	-	-	-	-	-	-	-	-	3,936	737	4,673
	Member Months (**Plans with PD benefits**)	12	-	12	9,473	1,838	11,311	39,133	7,071	46,204	-	-	-	-	-	-	-	-	-	-	-	-	48,618	8,909	57,527
	Premiums/Claims																								
2	Premium	2,874	-	2,874	3,658,257	690,328	4,348,585	15,721,439	2,863,457	18,584,896			-			-			-			-	19,382,569	3,553,785	22,936,354
	Claims/Medical Expenses	1,660	-	1,660	3,100,638	454,637	3,555,275	14,393,951	2,773,596	17,167,547			-			-			-			-	17,496,249	3,228,233	20,724,482
	Inpatient Facility																								
	Hospital																								
1	In-state	-	-	-	441,217	49,217	490,434	2,717,530	156,826	2,874,356			-			-			-			-	3,158,748	206,043	3,364,791
2	Out-of-state	-	-	-	52,816	12,154	64,969	487,911	347,844	835,755			-			-			-			-	540,726	359,998	900,724
3	Total (Lines 1 + 2)	-	-	-	494,033	61,371	555,404	3,205,441	504,670	3,710,111	-	-	-	-	-	-	-	-	-	-	-	-	3,699,474	566,041	4,265,515
	SNF																								
3 4	In-state	-	-	-	7,542	-	7,542	25,612	5,624	31,236			-			-			-			-	33,154	5,624	38,778
5	Out-of-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
6	Total (Lines 4 + 5)	-	-	-	7,542	-	7,542	25,612	5,624	31,236	-	-	-	-	-	-	-	-	-	-	-	-	33,154	5,624	38,778
	Other																								
7	In-state	-	-	-	-	-	-	1,167	-	1,167			-			-			-			-	1,167	-	1,167
8	Out-of-state	-	-	-	-	-	-	-	12,761	12,761			-			-			-			-	-	12,761	12,761
9	Total (Lines 7 + 8)	-	-	-	-	-	-	1,167	12,761	13,928	-	-	-	-	-	-	-	-	-	-	-	-	1,167	12,761	13,928
10	**Total Inpatient Facility (Lines 3 + 6 + 9)**	-	-	-	501,575	61,371	562,946	3,232,220	523,056	3,755,276	-	-	-	-	-	-	-	-	-	-	-	-	3,733,795	584,427	4,318,222
	Outpatient Facility																								
	Hospital																								
11	In-state	-	-	-	514,964	32,443	547,407	2,837,431	178,261	3,015,692			-			-			-			-	3,352,396	210,704	3,563,100
12	Out-of-state	-	-	-	117,047	54,151	171,198	200,349	484,800	685,149			-			-			-			-	317,396	538,951	856,347
13	Total (Lines 11 + 12)	-	-	-	632,011	86,594	718,605	3,037,780	663,061	3,700,842	-	-	-	-	-	-	-	-	-	-	-	-	3,669,791	749,655	4,419,447
	SNF																								
14	In-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
15	Out-of-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
4 16	Total (Lines 14 + 15)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Freestanding Ambulatory Care Facility																								
17	In-state	-	-	-	160,253	5,262	165,515	586,997	48,705	635,702			-			-			-			-	747,250	53,967	801,218
18	Out-of-state	-	-	-	42,588	11,594	54,182	126,262	90,297	216,558			-			-			-			-	168,850	101,890	270,740
19	Total (Lines 17 + 18)	-	-	-	202,841	16,856	219,698	713,259	139,002	852,260	-	-	-	-	-	-	-	-	-	-	-	-	916,100	155,858	1,071,958
	Other																								
20	In-state	1,420	-	1,420	109,081	7,179	116,260	617,925	10,551	628,476			-			-			-			-	728,426	17,731	746,156
21	Out-of-state	-	-	-	15,956	30,833	46,788	130,386	109,966	240,352			-			-			-			-	146,342	140,799	287,140
22	Total (Lines 20 + 21)	1,420	-	1,420	125,037	38,012	163,048	748,311	120,517	868,828	-	-	-	-	-	-	-	-	-	-	-	-	874,767	158,529	1,033,296
23	**Total Outpatient Facility (Lines 13 + 16 + 19 + 22)**	1,420	-	1,420	959,889	141,462	1,101,351	4,499,350	922,580	5,421,930	-	-	-	-	-	-	-	-	-	-	-	-	5,460,659	1,064,042	6,524,701

5		**Primary Care**																							
	24	**Total Primary Care**	-	-	-	236,566	66,277	302,843	878,870	153,449	1,032,319			-			-			-			-	1,115,436	219,726	1,335,162
6		**Pharmacy**																							
	25	**Total Pharmacy**			-	560,457	63,013	623,470	2,500,130	482,738	2,982,868			-			-			-			-	3,060,587	545,750	3,606,337
7		**Medical/Surgical other than primary care**																							
	26	In-state	107	-	107	500,447	25,883	526,330	1,872,922	107,942	1,980,864			-			-			-			-	2,373,477	133,824	2,507,301
	27	Out-of-state	-	-	-	100,752	54,851	155,604	328,431	377,542	705,973			-			-			-			-	429,183	432,394	861,577
	28	**Total Other Medical/Surgical (Lines 26 + 27)**	107	-	107	601,200	80,734	681,934	2,201,353	485,484	2,686,837	-	-	-	-	-	-	-	-	-	-	-	-	2,802,660	566,218	3,368,878
8		**All other payments to medical providers**																							
	29	**Total**	133	-	133	240,951	41,780	282,732	1,082,028	206,290	1,288,317			-			-			-			-	1,323,112	248,070	1,571,182

2012 Rate Review Process
Areas of Medical Expense Variation

Introductory Remarks

The stated goal of this exercise is to improve OHIC's understanding of the drivers of rising medical spending in Rhode Island by comparing the experience of the issuer's Rhode Island member base to a benchmark. For the purposes of this analysis, we have used our 2011 fully insured MA HMO experience as the benchmark. However, given the size of Tufts Health Plan's membership base in Rhode Island, the results of this comparative analysis will have limited credibility. Our relative costs by area of care have changed significantly in Rhode Island from year to year and are expected to continue to be volatile as our population in this market grows. Although we have commented on the probable causes of each variation listed, these fundamentally reflect a small, immature market compared to a much larger, more mature benchmark and should be interpreted with caution.

1. The top five areas of care, based on *per capita total dollar value* positive variation from the benchmark

Area of Care	Total Excess Spending	PMPM Excess Spending	Comments on Estimated Cause
INPATIENT ACUTE MED/SURG	$1,339,638	$23.29	Attributable to higher utilization (both admits and ALOS), rather than unit cost. High cost claimants identified as having a disproportionately large impact. The higher number of admits may be a consequence of lower than benchmark outpatient professional care.
PHARMACY - Rx MM	$717,042	$12.46	Attributable to higher utilization across tiers and therapeutic classes. Higher utilization driven by more members in RI having prescriptions filled than in the benchmark population, rather than a higher number of prescriptions per member.
OUTPATIENT LABORATORY	$558,538	$9.71	Capitation strategy applied in the benchmark population successfully contains cost.
OUTPATIENT INJECTIONS	$425,609	$7.40	Driven primarily by a difference in payment methodology between RI and the benchmark population. Injection claims in RI are reimbursed on a fee for service basis while in the benchmark population they are reimbursed on a fee for service basis or bundled into an outpatient surgery case payment. More than 50% of the higher RI utilization is associated with outpatient surgery claims, which would not be separately identified in the benchmark population.
OUTPATIENT EMERGENCY ROOM	$406,508	$7.07	Attributable primarily to a higher cost per emergency room encounter. This higher cost per encounter is driven less by higher unit cost in RI and more by the higher number of services delivered within an emergency room encounter compared to the benchmark.

2. The top five areas of care, based on *the percent of positive variation in per capita spending* from the benchmark

Area of Care	Percent of Positive Variation	Total Excess Spending	Comments on Estimated Cause
OUTPATIENT INJECTIONS	158%	$425,609	Driven primarily by a difference in payment methodology as described above.
FREE STANDING HIGH COST RADIOLOGY (MRI, PET, CT)	124%	$130,764	Higher utilization of allied health facilities, along with lower Outpatient Hospital High Cost Radiology utilization, reflects appropriate re-direction of care to lower cost providers.
OUTPATIENT LABORATORY	96%	$558,538	Capitation strategy applied in the benchmark population successfully contains cost.
INPATIENT OTHER	74%	$117,886	Driven by Mental Health/Substance Abuse services. Capitation strategy for inpatient Mental Health/Substance Abuse within the benchmark population effective at containing costs.
OUTPATIENT EMERGENCY ROOM	63%	$406,508	Attributable primarily to the number of services delivered within an emergency room encounter, as described above.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Provider Contracting Practices and Hospital Contracting Conditions Verification Questionnaire

Background

The Health Insurance Advisory Council (HIAC) to the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) has promulgated Affordability Standards for commercial health insurance issuers in Rhode Island.

Health plans will improve the affordability of health care in Rhode Island by focusing their efforts upon provider payment reform, beginning with primary care. Achievement of this goal will not add to overall medical spend in the short-term, and is expected to produce savings thereafter. Specific areas of focus in support of this goal are as follows:

1. Expand and improve the primary care infrastructure in the state—with limitations on ability to pass on cost in premiums
2. Spread Adoption of the "Chronic Care Model" Medical Home
3. Standardize electronic medical record (EMR) incentives
4. Work toward comprehensive payment reform across the delivery system

To support standard four, OHIC has previously issued six conditions for issuer contracts with hospitals in Rhode Island, to be implemented by issuers upon contract execution, renewal, or extension. These are as follows:

1. Utilize unit of service payment methodologies for both inpatient and hospital outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee for service.
2. Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index ("Index"), for all contractual and optional years covered by the contract
3. Provide the opportunity for hospitals to increase their total annual revenue for

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

commercially insured enrollment under the contract by at least additional two percentage points over the previous contract year by improving or attaining mutually agreed-to performance levels for no less than three nationally-accepted clinical quality, service quality or efficiency-based measures.

4. Include terms that define the parties' mutual obligations for greater administrative efficiencies
5. Include terms that promote and measure improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers.
6. Include terms that explicitly relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement.

The purpose of this questionnaire is to assess compliance with standard four of the Affordability Standards and to consider the responses in connection with OHIC's 2012 small and large employer group rate factor review process for commercial health insurance issuers in Rhode Island.

Directions

1. Please fill out all parts of questionnaire.
2. As no providers are identified and no financial details are solicited, none of this information will be considered proprietary or confidential. Should any information or document be considered confidential by the filer, the filer must request approval of the Health Insurance Commissioner. The request must identify the specific information or document (or portion thereof) which the filer considers confidential, accompanied by a factual and legal analysis supporting the request.
3. Questionnaire responses must be verified by filing those portions of each hospital contract which support the survey response. An index or other method of reference must be included to identify which hospital contract documentation relates to each survey response. Any contract excerpts provided will be summarized for review.
4. Please contact OHIC with any questions.

State of Rhode Island Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920-4407
(401) 462-9640
(401) 462-9645 (Fax)
www.ohic.ri.gov
THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

General comment:

Tufts Health Plan has a long standing commitment to investment in payer-provider incentive alignment, and we maintain hospital and physician incentive programs that apply to the vast majority of our network providers. As a relatively new entrant into the RI market, we are at an early stage of incorporating incentive mechanisms into our RI provider contracts. Provider incentive will be a key component of our contracting strategy as we grow our presence in the state of RI.

Tufts Health Plan requests that the information provided in response to this survey be deemed to constitute "trade secrets" within the meaning of the term in section 38-2-2(4)(i)(B) of the Rhode Island General Laws. We have included a footer stating "THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION".

Finally, due to the questionable reliability of certain information provided in our responses, which is explained in further detail below, it is Tufts Health Plan's expectation and understanding that the information provided in this Provider Survey will not be used or considered in OHIC's review of Tufts Health Plan's rates.

Part 1. Hospital Inpatient Services

- **Please fill out one row in the chart below for <u>each</u> general service institution (no specialty care, no rehab) with whom you contract in RI.**
- **Institution means hospital system if all contractual terms other than $ amounts apply identically across all inpatient facilities in the contract.**
- **Incentives refer to activities or measures resulting in additional payments by the insurer.**

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments

[1] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[2] Attach analysis and relevant documentation from contracts to demonstrate compliance status.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
1	3 Years	X DRG X Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	No	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [3]	__ admission reductions __ day reductions __ process/structural changes (e.g. discharge practices) __Others (please specify)	N/A (Contract has not been renegotiated)	
2	3 Years	x DRG x Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.5~1.0%____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
3	3 Years	__DRG __Per Diem x % of Charges __ Bundled Services	No	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

[3] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
		__ Capitation or other budgeting __Others (please specify)		incentive payments. 0.1~0.5%			
4	2 Years	__DRG x Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
5	3 Years	__DRG __Per Diem x % of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	No	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
6	3 Years	__DRG __Per Diem x % of Charges __ Bundled	No	No If yes - % of total payments for inpatient services in CY	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
		Services __ Capitation or other budgeting __Others (please specify)		2011 spent on quality incentive payments. _____			
7	1 Year	__DRG _x_Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. ____ 0-2%	_X_ admission reductions _X_ day reductions __Others (please specify)	Yes, please see attached	
8	3 Years	__DRG _x_Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

Additional Questions for Hospital Inpatient Services

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

1. List the five most common areas of quality and service incentives in your company's inpatient contracts:
(These measures apply to our hospital contracts that combine inpatient and outpatient services.)
   i. Joint Commission measures (e.g., AMI, CHF, pneumonia)
   ii. Leapfrog measures (e.g., CPOD, ICU staffing)
   iii. Prevention of "Never Events"
   iv. Surgical infection rates
   v. Readmission rates
2. Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2011 spent on quality incentive payments. 0.1~1%

3. Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2011 paid through units of service based on efficient resource use (i.e DRG, Capitation, Bundled Service or partial/global budgeting): <5%

4. Estimated Payments in first six months of CY 2011 for Inpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: See comment (add comments or caveats)

   For inpatient services Tufts Health Plan does not currently have the technical capability to benchmark to Medicare IPPS reimbursement. Conducting such analysis would require incremental time, resources and technical capabilities. Benchmarking Tufts Health Plan inpatient payments to Medicare IPPS may yield volatile and potentially unreliable results due to a) differences in reimbursement methodology (Tufts Health Plan reimburses the majority of inpatient claims on either a Per Diem or Percent of Charge basis); b) our relatively small volume of business in Rhode Island; c) mix of services; and d) chargemaster levels to some of the hospitals in Rhode Island. Additionally, it is our belief that a Medicare comparison for some hospitals that perform very specific services, like Obstetrics, will not result in a comparison that is useful and may lead to unintended and/or misinterpreted conclusions.

Other Comments on Quality/Efficiency Incentives in Hospital Inpatient Contracting:

Part 2. Hospital Outpatient Services

- **Please fill out one row in the chart below for each general service institution (no specialty care, no rehab) with whom you contract in RI.**
- **Institution means hospital system if all contractual terms other than dollar amounts apply identically across all inpatient facilities in the contract.**
- **Outpatient Services include any services not involving an admission and covered under the contract with the institution.**

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[4]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - %of total payments for inpatient services in CY 2011 spent on quality incentive payments. [5]	__ Visit/Volume Reduction __ Others (please specify)	
2	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.5~1.0%____	__ Visit/Volume Reduction __ Others (please specify)	
3	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.1~0.5%	__ Visit/Volume Reduction __ Others (please specify)	
4	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality	__ Visit/Volume Reduction __ Others (please specify)	

[4] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[5] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[4]?	Utilization Incentives in Contract: (check all that apply)	Comments
		incentive payments. _____		
5	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
6	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
7	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
8	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	

Additional Questions for Hospital Outpatient Services

1. List the five most common areas of quality and service incentives in your company's hospital outpatient contracts:

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

(These measures apply to our hospital contracts that combine inpatient and outpatient services.)

i. Joint Commission measures (e.g., AMI, CHF, pneumonia)
ii. Leapfrog measures (e.g., CPOD, ICU staffing)
iii. Prevention of "Never Events"
iv. Surgical infection rates
v. Readmission rates

2. Percent of total payments to RI Hospitals for outpatient services in CY 2011 spent on quality incentive payments. 0.1~1%

3. Percent of total payments to RI Hospitals for outpatient services in CY 2011 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): n/a

4. Estimated Payments in first six months of CY 2011 for Outpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: 222% (i.e. 122% over Medicare Reimbursement) (add comments or caveats)

   For Outpatient Services, Tufts Health Plan has the technical capabilities to perform the required benchmarking analysis to Medicare; however, we have concerns about the confidence level in the accuracy of the supplied benchmark. Our concerns are due to a) the allowed reimbursement at a claim level was compared to fee information obtained from OPPS and CMS ancillary schedules such as Clinical Lab, DME etc.; b) we are not able to reprocess our claims through an OPPS Grouper and were limited to a line level reprice based on OPPS/Ancillary fees which means that exact Medicare reimbursement can only be approximated; c) Procedures that do not have a fee on OPPS/Ancillary schedules, or are billed in a different manner to Medicare (e.g., observation) were dropped from the analysis.

   Additionally, Tufts Health Plan has concerns that the results may be skewed due to a few high-volume hospitals and the large number of providers reimbursed on a percent of charges basis – factors that may distort the data due to particular mix of services and chargemaster levels of PAF providers. Based on the concerns listed above it is our belief that a Medicare comparison might not result in a benchmark that is useful and could lead to unintended and/or misinterpreted conclusions that if made public could impact certain contract negotiations by putting upward pressure on unit costs.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Other Comments on Quality/Efficiency Incentives in Hospital Outpatient Contracting:

Part 3: Professional Groups

- **"Professional Groups" is defined as non institutional/non facility groups with a valid contract and a single tax id number.**
- **Please provide information for the top 10 groups (measured by $ paid in 2011), filling in one row per group (10 rows in the table total).**

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	Multi-specialty	x Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [7] _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services _ Others (please specify)	
2	Multi-specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
3	Multi-specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code	No If yes - % of total payments for inpatient services in CY 2011 spent	__Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care	

[6] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[7] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
		__ Full/ Partial Capitation __Other (please specify)	on quality incentive payments. _____	__ use of pharmacy services __ Others (please specify)	
4	Sub - Specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
5	Primary Care	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
6	Primary Care	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0~5%	x Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care x use of pharmacy services x Others (please specify)	Quality/Member Satisfaction
7	Sub - Specialty	_ X _ Procedure-based methodology – using CPT, plan,	No	__ Visit/Volume Reduction __use of ancillary/referred services	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
		provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments.	__ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
8	Sub - Specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
9	Multi-specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
10	Multi-specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Additional Questions for Professional Groups

1. List the five most common areas of quality and service incentives in your company's professional group contracts:
   i. HEDIS (diabetes, breast cancer screening, colonoscopy, etc.)
   ii. HCHAPS
   iii. EMR adoption
   iv. Inpatient and ER use
   v. Rx Management
2. Percent of total payments to these ten professional groups in CY 2011 spent on quality incentive payments. ___<1%_____

3. Percent of total payments to these ten professional groups in CY 2011 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): ___n/a_____

4. Estimated Payments in first six months of CY 2011 for Professional Group Services as % of what Medicare would have paid for similar set. of services: 122% (i.e. 22% over Medicare Reimbursement) (add comments or caveats)

   The analysis was conducted using a claim line level comparison between allowed reimbursement and Medicare fee information obtained from RBRVS tables as well as Medicare ancillary schedules such as clinical lab, DME etc. Anesthesia services were also included. Procedures that Medicare does not reimburse but supplies RVU information for, such as preventive medicine and consults codes, are included at the RVU level rate for the Medicare comparison. Claims lines that do not have RBRVS/Ancillary schedule information were dropped from the analysis.

   Additionally, Tufts Health Plan has concerns that the results may be skewed due to particular mix of services for providers. Based on the concerns listed above it is our belief that a Medicare comparison might not result in a benchmark that is useful and could lead to unintended and/or misinterpreted conclusions that if made public could impact certain contract negotiations by putting upward pressure on unit costs.

Other Comments on Quality/Efficiency Incentives in Professional Group Contracting:

Selected Contract Sections Showing Compliance To OHIC Conditions

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Effective for dates of service on or after January 1, 2011

Office of the Health Insurance Commissioner Conditions

Pay-For-Performance: **[Redacted]** is available for the Hospital to earn based upon quality and/or efficiency measures **[redacted]**.

Case Rates: In the event **[redacted]** parties agree to meet to discuss the potential to transition to efficiency based payment methodologies (e.g., DRG, APC) in a manner that **[redacted]**.

Administrative Efficiency: Tufts Health Plan agrees to assign a Contract Specialist to provide ongoing contract related support through the term of the agreement to help mitigate contract related issues.

The Hospital agrees to work with and communicate issues to the Contract Specialist on an ongoing basis and work in good faith to resolve contract related issues in a timely manner.

Communication: During calendar year 2011 parties agree to formalize clinical communication that promotes and measures improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers.

Public Release of Contract Terms: Parties agree to allow the public release of terms outlined in this agreement if compelled by State regulatory authorities.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

1. Please provide an excel spreadsheet in the following format, detailing the 2011 actual and 2013 requested small and large group administrative costs pmpm, allocated among the NAIC- financial statement administrative cost categories. Please explain any significant changes from the financial filing for 2011 (increases/decreases of more than five percent in a particular category).

RI Insured HMO	2011 Actual (from filed financial statements)		2013 Proposed		% Change	
	Small Group	Large Group	Small Group	Large Group	Small Group	Large Group
Total Estimated Member Months	4,509	18,246	4,480	19,600	-0.6%	7.4%
Total Estimated Premiums ($pmpm)	$378.21	$397.92	$417.71	$439.41	10.4%	10.4%
Total General Administrative Expense	$41.82	$41.20	$43.68	$41.50	4.4%	0.7%
Total Cost Containment Expense	$10.43	$9.64	$10.10	$10.10	-3.2%	4.7%
Total Other Claim Adjustment Expense ($pmpm)	$7.99	$7.38	$7.73	$7.73	-3.2%	4.7%
Breakdown of General Administrative Expense ($pmpm)						
a. Payroll and benefits	$2.94	$2.72	$2.85	$2.85	-3.2%	4.7%
b. Outsourced Services (EDP, claims etc.)	$0.09	$0.09	$0.09	$0.09	-3.2%	4.7%
c. Auditing and consulting	$8.02	$7.42	$7.77	$7.77	-3.2%	4.7%
d. Commissions	$13.59	$14.62	$15.24	$13.06	12.1%	-10.6%
e. Marketing and Advertising	$1.76	$1.63	$1.71	$1.71	-3.2%	4.7%
f. Legal Expenses	$0.17	$0.16	$0.16	$0.16	-3.2%	4.7%
g. Taxes, Licenses and Fees	$7.56	$7.96	$8.83	$8.83	16.8%	11.0%
h. Reimbursements by Uninsured Plans	$0.00	$0.00	$0.00	$0.00	0.0%	0.0%
i. Other Admin Expenses	$7.68	$6.62	$7.04	$7.04	-8.4%	6.4%

Notes
1. The expense in any given administrative category may vary from year to year due to the small size of Tufts Health Plan's HMO block of business in Rhode Island. In aggregate, however, total admin has increased less than about 3% per year.

2. Please also provide an excel spreadsheet in the following format; detailing actual calendar year 2007-2011 fully insured commercial administrative costs, in accordance with the following table. This should be consistent with the annual statement filings to OHIC for administrative costs, providing additional detail on the components of administrative costs using the categories defined by NAIC financial statement and as allocated to commercially insured business only. Specifically, the information provided should agree with the "Exhibit of Premiums, Enrollment and Utilization" and the "Analysis of Operations by Line of Business" schedules included in the Annual Statements on file with OHIC. Where there are variance, a reconciliation and explanation should be provided.

Fully Insured Commercial Administrative Cost History

RI Insured HMO	2007	2008	2009	2010	2011
Total Premiums			1,212,134	6,544,977	8,965,746
Total General Administrative Expense			192,865	732,653	940,237
General Admin Exp. Ratio			15.9%	11.2%	10.5%
Total Fully Insured Member Months			3,878	18,547	22,755
General Administrative Expense ($pmpm)			$49.73	$39.50	$41.32
Breakdown of General Administrative Expense ($pmpm)					
a. Payroll and benefits			$3.37	$2.49	$2.76
b. Outsourced Services (EDP, claims etc.)			$0.01	$0.01	$0.09
c. Auditing and consulting			$5.92	$4.93	$7.54
d. Commissions			$11.74	$16.10	$14.41
e. Marketing and Advertising			$2.52	$1.72	$1.66
f. Legal Expenses			$0.08	$0.11	$0.16
g. Taxes, Licenses and Fees			$6.25	$7.06	$7.88
h. Reimbursements by Uninsured Plans			$0.00	$0.00	$0.00
i. Other Admin Expenses			$19.85	$7.03	$6.83
Cost Containment Expense			20,663	158,478	222,967
Other Claim Adjustment Expense			27,194	151,819	170,707
Total Self Insured Member Months for all Affiliated Companies doing business in RI			113,694	0	662

Notes:
1. Total premiums for 2010 differ from the aggregate amount submitted in last year's filing, but are consistent with the individual small and large group figures submitted last year.

RI Insured HMO

3. At the request of OHIC's Health Insurance Advisory Council, please provide brief answers to the following questions

- **In general and net of new taxes and fees, why should the rate of increase in Health Plan administrative costs exceed the general inflation rate?**

  Administrative expenses in total in a given year are adjusted for inflation, membership growth or loss and increases or decreases in corporate projects, which are often driven by regulatory requirements and government mandates. As a general practice, to set administrative expense targets for the annual financial plan, fixed administrative costs are grown at an inflationary rate. Variable administrative costs are then developed by applying inflation to the variable pmpm rate and then multiplying the inflated pmpm rate by planned member months. While those are the initial steps to develop targets, each administrative function is reviewed in detail to identify potential administrative cost savings and targets are adjusted accordingly.

- **What percentage of administrative costs does your organization consider fixed for the next five years? Provide detail by expense categories.**

  For the total company, we currently consider 58% of our costs fixed as follows:

Fixed Administrative Costs by Category:	
Network Management	2%
Sales and Marketing	4%
Clinical Services	5%
Operations	5%
IT & Business Effectiveness	8%
Corporate Projects	14%
Fixed Overhead and Other	20%
Total Fixed Administrative Expenses	58%

- **What administrative services are used by fully insured members that are not used by self-insured clients (e.g. broker commissions) and what are the estimated total costs ($pmpm) for those services?**

  Administrative costs for fully insured membership include expenses associated with medical cost containment ($9.80 pmpm), whereas in most cases self-insured clients bear these costs directly. Broker commissions ($14.41 pmpm) are also not applicable to most self-insured clients.

- **What does your plan use as its pmpm benchmarks or price points for commercial insurance administrative costs and why?**

We periodically participate in the benchmarking survey used to develop the *Sherlock Expense Evaluation Reports* (SEER) which are viewed as the definitive benchmarks for the functional areas of health plan administration. The Sherlock Expense Evaluation Reports (SEER) supply comprehensive and highly granular financial and operational metrics.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Health System Improvements Survey

The State of Rhode Island Office of the Health Insurance Commissioner Regulation 2 lists standards to be used by the Health Insurance Commissioner (Commissioner) for the assessment of the conduct of commercial health insurance issuers in Rhode Island for their efforts aimed at improving the efficiency and quality of health care delivery and increasing access to health care services. The standards include the following issuer activities:

1. Directing resources, including financial contributions, toward system-wide improvements in the state's health care system related to quality, access and efficiency, including providing support to local collaboratives, organizations, and initiatives that promote these three goals

2. Participating in the development and implementation of public policy issues related to health

To assist the Commissioner in this assessment, as part of the 2012 small and large employer group rate factor review process for commercial health insurance issuers in Rhode Island, please itemize and quantify your organization's contributions of finances and other material assets to these efforts in Rhode Island in calendar year 2011 in the following table.[1]

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
Funding	Grants provided by the Tufts Health Plan Foundation and Community Relations to the following RI organizations to support wellness and safety initiatives • **Best Buddies International** *Best Buddies Intergenerational College Project* Grant Amount: $20,000 • **Mount St. Rita Health Centre** *Blessings in a Back Pack* Grant Amount: $5,000 • **Bethany Home of Rhode Island Inc.**	**$515,724**

[1] The contributions can be to any entity other than a provider to improve medical and prevention services for all Rhode Islanders and to promote a coherent, integrated, and efficient statewide health care system.

State of Rhode Island Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920-4407
(401) 462-9640
(401) 462-9645 (Fax)
www.ohic.ri.gov

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
	Bethany Home Cares Grant Amount: $43,036 • **Homefront Health Care** *HIP-SAFE (Homefront Intervention to Prevent Slips & Falls in Elders)* Grant Amount: $59,438 • **Rhode Island Free Clinic Inc.** *Healthy Lifestyles for Today and Tomorrow* Grant Amount: $60,000 • **The Providence Center** *InShape Seniors* Grant Amount: $42,000 • **Ocean State Center for Independent Living (OSCIL)** *Home Sweet Accessible Home* Grant Amount: $40,000 • **Westbay Community Action Inc.** *Elder Safety* Grant Amount: $42,000 • **Rhode Island Quality Institute** *Health Information Exchange Support* Grant Amount: $25,000 • **EMR Payments** $179,250	

Participation in RI initiatives, programs and organizations	The goals of these programs, initiatives and organizations is to improve quality and/or transform primary care in the state:
	• CSI/Beacon (Project director, project manager, and nurse case manager support) $38,329
	• Value of Resource Time in Various Programs (Estimate of $30,000 for 0.2 FTE for 2011)
	  ○ RI DOH Medical Director meetings
	  ○ RI Quality Partners Safe Transitions
	  ○ RI Senate Commission on Hospital Payment Reform
	  ○ RIQI Board of Directors
	  ○ RI CSI Beacon Executive Committee
		$68,329

Thank you for your cooperation.

Tufts Insurance Company

Large Group Rate Filing -- Effective Date January 1, 2013

Part 1. Historical Information

Experience Period for Developing Rates	
From	**To**
01/01/2009	12/31/2011

Utilization/Experience Data by Quarter (Last 12 Available Quarters)

Quarter	End Date	IP Days	Member Months	Earned Premium	Incurred Claims Total	Incurred Claims IP	Incurred Claims OP	Incurred Claims Primary Care	Incurred Claims Other M/S	Incurred Claims Rx	Loss Ratio	Quality Improvement Expense*	Other Cost Containment Expense*	Other Claim Adjustment Expense*	Other Operating Expense*	Investment Income Credit	Commissions	Contribution to Reserves
1 (Oldest)	03/31/2009	82	2,357	$895,234	$778,094	$167,486	$266,832	$42,046	$188,476	$113,254	88.9%	$17,395	$10,077	$13,183	$79,159	N/A	$37,942	($40,615)
2	06/30/2009	138	4,984	$1,886,389	$1,428,578	$305,927	$382,248	$98,764	$365,250	$276,390	77.7%	$36,783	$21,309	$27,876	$167,386	N/A	$80,230	$124,227
3	09/30/2009	155	6,727	$2,578,593	$2,534,421	$946,384	$554,008	$120,535	$532,806	$380,690	100.2%	$49,647	$28,762	$37,625	$225,924	N/A	$108,288	($406,074)
4	12/31/2009	199	7,532	$2,856,684	$2,493,403	$480,304	$619,165	$149,673	$763,475	$480,786	89.2%	$55,189	$31,973	$41,826	$251,526	N/A	$120,377	($137,609)
5	03/31/2010	267	9,113	$3,524,916	$3,133,741	$881,025	$716,794	$180,987	$838,087	$516,848	90.8%	$65,248	$30,966	$40,509	$235,871	N/A	$140,525	($121,943)
6	06/30/2010	138	8,349	$3,238,492	$2,462,532	$388,858	$691,211	$155,553	$749,782	$477,128	77.9%	$59,789	$28,375	$37,119	$216,122	N/A	$128,767	$305,789
7	09/30/2010	175	8,310	$3,350,598	$2,633,548	$515,443	$660,800	$167,904	$777,512	$511,888	80.4%	$59,623	$28,296	$37,017	$215,385	N/A	$128,410	$248,319
8	12/31/2010	132	8,441	$3,427,920	$2,898,658	$553,078	$761,074	$178,201	$877,069	$529,237	86.3%	$60,544	$28,733	$37,588	$218,734	N/A	$130,393	$53,268
9	03/31/2011	152	7,667	$3,132,702	$2,649,905	$527,237	$755,459	$144,295	$766,889	$456,025	86.2%	$49,674	$31,249	$38,226	$191,980	N/A	$109,362	$62,306
10	06/30/2011	103	7,107	$2,918,613	$2,292,577	$311,627	$678,477	$146,187	$680,221	$476,065	80.1%	$46,046	$28,966	$35,434	$177,958	N/A	$101,374	$236,259
11	09/30/2011	173	6,677	$2,680,582	$2,663,871	$587,051	$728,870	$135,681	$751,308	$460,960	101.0%	$43,260	$27,214	$33,290	$167,191	N/A	$95,241	($349,484)
12	12/31/2011	132	6,620	$2,653,346	$2,408,236	$371,964	$657,269	$154,051	$759,233	$465,719	92.4%	$42,890	$26,981	$33,006	$165,764	N/A	$94,428	($117,959)

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3- Analysis of Expenses and/or to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1
If any of the historical information reported is different from that period as reported in the prior rate filing, please provide a reconciliation and explanation showing the amount of each element of difference.

Notes:
1. The Other Operating Expenses shown above include taxes, licenses and fees, which were excluded in previous filings for the same time periods
2. Primary care claims definition has been revised to match the Primary Care Spend report
3. Expenses such as network access fee, COB and claims interest are moved from Other M/S claims to administrative expenses according to NAIC definition
4. Claims Total differences from the previous filings for the same time periods are due to updated IBNR factors that reflect more up to date claims payment, as well as the revision to the Other M/S claims definition
5. Loss ratio is calculated as (Incurred Claims Total + Quality Improvement Expense) / Earned Premium

Part 2. Prospective Information

A. 2013 Trend Factors for Projection Purposes (Annualized)

	IP	OP	Primary Care	Other M/S	Rx	Weighted Total
Total	5.2%	6.7%	5.4%	4.7%	4.7%	5.4%
Price Only	3.6%	3.4%	3.3%	1.8%	0.8%	2.6%
Utilization	1.5%	3.2%	2.0%	2.9%	3.9%	2.8%
Other**						
Other**						
Other**						
Weights	20.4%	26.5%	9.4%	26.3%	17.4%	**100%**

** All elements should add or compound to the total. If anything is to be reported as "Other" please provide a description.

2012 Trend Factors for Projection Purposes (Annualized)

	IP	OP	Primary Care	Other M/S	Autism Mandate	Rx	Weighted Total
Total	5.9%	7.6%	6.4%	4.8%	0.2%	0.3%	5.3%
Price Only	3.6%	3.7%	4.1%	1.3%		-3.6%	1.9%
Utilization	2.2%	3.8%	2.2%	3.5%		4.0%	3.3%
Other**							
Other**							
Other**							
Weights	20.2%	24.7%	8.4%	29.3%		17.4%	**100%**

** All elements should add or compound to the total. If anything is to be reported as "Other" please provide a description.

B. The following items for the period to which the rate filing applies, by quarter:

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %
1	01/01/2013	6.8%	85.7%	0.0%	1.6%	1.1%	1.4%	4.5%	2.7%	0.0%	3.0%
2	04/01/2013	6.5%	85.7%	0.0%	1.6%	1.1%	1.4%	4.5%	2.7%	0.0%	3.0%
3	07/01/2013	6.6%	85.7%	0.0%	1.6%	1.1%	1.4%	4.5%	2.7%	0.0%	3.0%
4	10/01/2013	6.8%	85.7%	0.0%	1.6%	1.1%	1.4%	4.5%	2.7%	0.0%	3.0%
Weighted Average		6.7%	85.7%	0.0%	1.6%	1.1%	1.4%	4.5%	2.7%	0.0%	3.0%

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %
1	01/01/2012	3.4%	87.0%	0.0%	1.1%	0.8%	1.1%	5.0%	2.7%	0.0%	2.3%
2	04/01/2012	3.0%	87.0%	0.0%	1.1%	0.8%	1.1%	5.0%	2.7%	0.0%	2.3%
3	07/01/2012	4.0%	87.0%	0.0%	1.1%	0.8%	1.1%	5.0%	2.7%	0.0%	2.3%
4	10/01/2012	6.6%	87.0%	0.0%	1.1%	0.8%	1.1%	5.0%	2.7%	0.0%	2.3%
Weighted Average		4.2%	87.0%	0.0%	1.1%	0.8%	1.1%	5.0%	2.7%	0.0%	2.3%

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3 - Analysis of Expenses and to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1
The sum of the expenses, commissions, contributions to reserves, investment income credit, taxes and the medical loss ratio should be 100%.

C. Average Rate Increase Components

The following items should reconcile to the Weighted Average Percent Rate Increase for the year:

	Price	Utilization, Mix	Total
Hospital Inpatient Price	0.6%	0.3%	0.9%
Hospital Outpatient	0.8%	0.7%	1.5%
Primary Care	0.3%	0.2%	0.4%
Med/Surg Other Than Primary Care	0.4%	0.6%	1.0%
Pharmacy	0.1%	0.6%	0.7%
Administrative Expense (Aggregated)			0.6%
Contribution to Reserves			0.0%
Taxes and Assessments			0.9%
Legally Mandated Changes			0.0%
Prior Period Adjustment (+/-)			0.6%
Total			6.7%

Note:
1. Due to the lack of credible experience, manual rates are developed by trending forward prior base rates to reflect trend changes. Therefore, depending on the timing of trend change, rate increases may be different from trend increase. The difference is reflected as Prior Period Adjustment above.

Part 3. Retrospective Reconciliation of Experience with Filed Factors

	Filed Data[1]					PMPM Increase[2]		Standard Plan PMPM[3]		Standard Plan Increase[4]		Approved		Loss Ratio	
Year	Member Months	Earned Premium	Incurred Claims Total	Premium PMPM	Claims PMPM	Premium	Claims	Premium	Claims	Premium	Claims	Trend Increase%	Contrib to Reserves%	Actual%	Filed%
2009	21,600	8,216,900	7,393,509	$380.41	$342.29			-	-			9.7%	0%	90.0%	87.0%
2010	34,213	13,541,926	11,373,683	$395.81	$332.44	4.0%	-2.9%	370.55	341.89	N/A	N/A	9.3%	0%	84.0%	87.0%
2011	28,071	11,385,244	10,196,459	$405.59	$363.24	2.5%	9.3%	-	-	N/A	N/A	9.2%	0%	89.6%	88.1%

[1] Corresponds to historical Information data in Part 1 above

[2] Percent increase compared to prior year

[3] For most commonly held plan of benefits in 2010 and for the same plan of benefits in 2011
Note that the most commonly held plan of benefits in 2010 was not held by any plan in either 2009 or 2011

[4] Percent increase compared to prior year

Note:
1. Filed loss ratio for CY 2011 is the sum of the expected pure medical cost ratio and expected quality improvement expenses % in 2011 rate factor filing

Rhode Island Health Statement Supplement

Cover Sheet

Company Name	**Tufts Associated Health Maintenance Organizations & Tufts Insurance Company**		
Enter NAIC#	**95688 & 60177**	**Reporting Year**	**2011**
Enter DBR registration # (TPAs)			

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Office of the Health Insurance Commissioner
1511 Pontiac Ave, Building #69 first floor
Cranston, RI 02920
(401) 462-9517
(401) 462-9645 (fax)
HealthInsInquiry@ohic.ri.gov

Line of Business Exhibit

Field			1 Comprehensive/Major medical			2 ASO/TPA			3 Stop loss/ Excess loss/Reinsurance			4 Medicare Part C			5 Medicare Part D			6 Medicare Supplement Policies			7 Medicaid/Other public			8 Student blanket			9 Dental Only			10 Other Medical Non-Comprehensive			11 Total (Across all lines of business)		
			RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
1		**Membership Data**																																
		Number of Polices or Certificates	197	-	197	1	-	1			-			-	91		91	3	-	3			-			-			-			-	292	-	292
		Number of Covered Lives	3,936	737	4,673	299	29	328			-			-	91		91	5	-	5			-			-			-			-	4,331	766	5,097
		Member Months	48,618	8,909	57,527	603	59	662			-			-	1,062		1,062	60	-	60			-			-			-			-	50,343	8,968	59,311
		Number of Polices or Certificates (**Plans with PD benefits**)	197	-	197	1	-	1	-	-	-	-	-	-	91	-	91	3	-	3	-	-	-	-	-	-	-	-	-	-	-	-	292	-	292
		Number of Covered Lives (**Plans with PD benefits**)	3,936	737	4,673	299	29	328	-	-	-	-	-	-	91	-	91	5	-	5	-	-	-	-	-	-	-	-	-	-	-	-	4,331	766	5,097
		Member Months (**Plans with PD benefits**)	48,618	8,909	57,527	603	59	662	-	-	-	-	-	-	1,062	-	1,062	60	-	60	-	-	-	-	-	-	-	-	-	-	-	-	50,343	8,968	59,311
2		**Premiums/Claims**																																
		Premium	19,382,569	3,553,785	22,936,354	162,614	18,088	180,702			-			-	146,221		146,221	23,160	-	23,160			-			-			-			-	19,714,564	3,571,873	23,286,437
		Claims/Medical Expenses	17,496,249	3,228,233	20,724,482	139,151	15,072	154,222			-			-	405,690		405,690	20,052	-	20,052			-			-			-			-	18,061,142	3,243,305	21,304,446
3		**Inpatient Facility**																																
		Hospital																																
	1	In-state	3,158,748	206,043	3,364,791	17,550	-	17,550			-			-			-	-	-	-			-			-			-			-	3,176,298	206,043	3,382,341
	2	Out-of-state	540,726	359,998	900,724	-	-	-			-			-			-	-	-	-			-			-			-			-	540,726	359,998	900,724
	3	Total (Lines 1 + 2)	3,699,474	566,041	4,265,515	17,550	-	17,550	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3,717,024	566,041	4,283,065
		SNF																																
	4	In-state	33,154	5,624	38,778	-	-	-			-			-			-	-	-	-			-			-			-			-	33,154	5,624	38,778
	5	Out-of-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	6	Total (Lines 4 + 5)	33,154	5,624	38,778	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	33,154	5,624	38,778
		Other																																
	7	In-state	1,167	-	1,167	-	-	-			-			-			-	-	-	-			-			-			-			-	1,167	-	1,167
	8	Out-of-state	-	12,761	12,761	-	-	-			-			-			-	-	-	-			-			-			-			-	-	12,761	12,761
	9	Total (Lines 7 + 8)	1,167	12,761	13,928	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,167	12,761	13,928
	10	**Total Inpatient Facility (Lines 3 + 6 + 9)**	3,733,795	584,427	4,318,222	17,550	-	17,550	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3,751,345	584,427	4,335,772
4		**Outpatient Facility**																																
		Hospital																																
	11	In-state	3,352,396	210,704	3,563,100	22,675	916	23,591			-			-			-	1,633	-	1,633			-			-			-			-	3,376,704	211,620	3,588,324
	12	Out-of-state	317,396	538,951	856,347	1,088	1,834	2,922			-			-			-	-	-	-			-			-			-			-	318,484	540,785	859,269
	13	Total (Lines 11 + 12)	3,669,791	749,655	4,419,447	23,763	2,749	26,512	-	-	-	-	-	-	-	-	-	1,633	-	1,633	-	-	-	-	-	-	-	-	-	-	-	-	3,695,188	752,404	4,447,593
		SNF																																
	14	In-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	15	Out-of-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	16	Total (Lines 14 + 15)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
		Freestanding Ambulatory Care Facility																																
	17	In-state	747,250	53,967	801,218	1,893	-	1,893			-			-			-	-	-	-			-			-			-			-	749,143	53,967	803,110
	18	Out-of-state	168,850	101,890	270,740	-	4,631	4,631			-			-			-	-	-	-			-			-			-			-	168,850	106,521	275,371
	19	Total (Lines 17 +18)	916,100	155,858	1,071,958	1,893	4,631	6,524	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	917,993	160,489	1,078,482
		Other																																
	20	In-state	728,426	17,731	746,156	2,074	115	2,189			-			-			-	310	-	310			-			-			-			-	730,809	17,845	748,655
	21	Out-of-state	146,342	140,799	287,140	945	369	1,314			-			-			-	47	-	47			-			-			-			-	147,334	141,167	288,501
	22	Total (Lines 20 + 21)	874,767	158,529	1,033,296	3,019	484	3,503	-	-	-	-	-	-	-	-	-	357	-	357	-	-	-	-	-	-	-	-	-	-	-	-	878,143	159,013	1,037,156
	23	**Total Outpatient Facility (Lines 13 + 16 + 19 + 22)**	5,460,659	1,064,042	6,524,701	28,676	7,864	36,539	-	-	-	-	-	-	-	-	-	1,990	-	1,990	-	-	-	-	-	-	-	-	-	-	-	-	5,491,325	1,071,906	6,563,231
5		**Primary Care**																																
	24	**Total Primary Care**	1,115,436	219,726	1,335,162	15,201	842	16,043			-			-			-	679	-	679			-			-			-			-	1,131,316	220,567	1,351,883
6		**Pharmacy**																																
	25	**Total Pharmacy**	3,060,587	545,750	3,606,337	44,737	1,491	46,227			-			-	405,690		405,690	10,316	-	10,316			-			-			-			-	3,521,330	547,241	4,068,570
7		**Medical/Surgical other than primary care**																																
	26	In-state	2,373,477	133,824	2,507,301	17,385	1,341	18,726			-			-			-	5,354	-	5,354			-			-			-			-	2,396,216	135,165	2,531,381
	27	Out-of-state	429,183	432,394	861,577	442	1,815	2,257			-			-			-	-	-	-			-			-			-			-	429,625	434,208	863,834
	28	**Total Other Medical/Surgical (Lines 26 + 27)**	2,802,660	566,218	3,368,878	17,828	3,155	20,983	-	-	-	-	-	-	-	-	-	5,354	-	5,354	-	-	-	-	-	-	-	-	-	-	-	-	2,825,841	569,374	3,395,215
8		**All other payments to medical providers**																																
	29	**Total**	1,323,112	248,070	1,571,182	15,159	1,720	16,880			-			-			-	1,714	-	1,714			-			-			-			-	1,339,986	249,790	1,589,776

Field	Market Exhibit (For Comprehensive/Major Medical Line of Business)	1 Individual			2 Small Group			3 Large Group			4 Association			5 Trust			6 Federal Employee Health Benefit Plan			7 Other Health Market			8 Total (Across all markets)		
		RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
	Membership Data																								
	Number of Polices or Certificates	1	-	1	165	-	165	31	-	31			-			-			-			-	197	-	197
	Number of Covered Lives	1	-	1	702	140	842	3,233	597	3,830			-			-			-			-	3,936	737	4,673
1	Member Months	12	-	12	9,473	1,838	11,311	39,133	7,071	46,204			-			-			-			-	48,618	8,909	57,527
	Number of Polices or Certificates (**Plans with PD benefits**)	1	-	1	165	-	165	31	-	31	-	-	-	-	-	-	-	-	-	-	-	-	197	-	197
	Number of Covered Lives (**Plans with PD benefits**)	1	-	1	702	140	842	3,233	597	3,830	-	-	-	-	-	-	-	-	-	-	-	-	3,936	737	4,673
	Member Months (**Plans with PD benefits**)	12	-	12	9,473	1,838	11,311	39,133	7,071	46,204	-	-	-	-	-	-	-	-	-	-	-	-	48,618	8,909	57,527
	Premiums/Claims																								
2	Premium	2,874	-	2,874	3,658,257	690,328	4,348,585	15,721,439	2,863,457	18,584,896			-			-			-			-	19,382,569	3,553,785	22,936,354
	Claims/Medical Expenses	1,660	-	1,660	3,100,638	454,637	3,555,275	14,393,951	2,773,596	17,167,547			-			-			-			-	17,496,249	3,228,233	20,724,482
	Inpatient Facility																								
	Hospital																								
1	In-state	-	-	-	441,217	49,217	490,434	2,717,530	156,826	2,874,356			-			-			-			-	3,158,748	206,043	3,364,791
2	Out-of-state	-	-	-	52,816	12,154	64,969	487,911	347,844	835,755			-			-			-			-	540,726	359,998	900,724
3	Total (Lines 1 + 2)	-	-	-	494,033	61,371	555,404	3,205,441	504,670	3,710,111	-	-	-	-	-	-	-	-	-	-	-	-	3,699,474	566,041	4,265,515
	SNF																								
3 4	In-state	-	-	-	7,542	-	7,542	25,612	5,624	31,236			-			-			-			-	33,154	5,624	38,778
5	Out-of-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
6	Total (Lines 4 + 5)	-	-	-	7,542	-	7,542	25,612	5,624	31,236	-	-	-	-	-	-	-	-	-	-	-	-	33,154	5,624	38,778
	Other																								
7	In-state	-	-	-	-	-	-	1,167	-	1,167			-			-			-			-	1,167	-	1,167
8	Out-of-state	-	-	-	-	-	-	-	12,761	12,761			-			-			-			-	-	12,761	12,761
9	Total (Lines 7 + 8)	-	-	-	-	-	-	1,167	12,761	13,928	-	-	-	-	-	-	-	-	-	-	-	-	1,167	12,761	13,928
10	**Total Inpatient Facility (Lines 3 + 6 + 9)**	-	-	-	501,575	61,371	562,946	3,232,220	523,056	3,755,276	-	-	-	-	-	-	-	-	-	-	-	-	3,733,795	584,427	4,318,222
	Outpatient Facility																								
	Hospital																								
11	In-state	-	-	-	514,964	32,443	547,407	2,837,431	178,261	3,015,692			-			-			-			-	3,352,396	210,704	3,563,100
12	Out-of-state	-	-	-	117,047	54,151	171,198	200,349	484,800	685,149			-			-			-			-	317,396	538,951	856,347
13	Total (Lines 11 + 12)	-	-	-	632,011	86,594	718,605	3,037,780	663,061	3,700,842	-	-	-	-	-	-	-	-	-	-	-	-	3,669,791	749,655	4,419,447
	SNF																								
14	In-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
15	Out-of-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
4 16	Total (Lines 14 + 15)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Freestanding Ambulatory Care Facility																								
17	In-state	-	-	-	160,253	5,262	165,515	586,997	48,705	635,702			-			-			-			-	747,250	53,967	801,218
18	Out-of-state	-	-	-	42,588	11,594	54,182	126,262	90,297	216,558			-			-			-			-	168,850	101,890	270,740
19	Total (Lines 17 + 18)	-	-	-	202,841	16,856	219,698	713,259	139,002	852,260	-	-	-	-	-	-	-	-	-	-	-	-	916,100	155,858	1,071,958
	Other																								
20	In-state	1,420	-	1,420	109,081	7,179	116,260	617,925	10,551	628,476			-			-			-			-	728,426	17,731	746,156
21	Out-of-state	-	-	-	15,956	30,833	46,788	130,386	109,966	240,352			-			-			-			-	146,342	140,799	287,140
22	Total (Lines 20 + 21)	1,420	-	1,420	125,037	38,012	163,048	748,311	120,517	868,828	-	-	-	-	-	-	-	-	-	-	-	-	874,767	158,529	1,033,296
23	**Total Outpatient Facility (Lines 13 + 16 + 19 + 22)**	1,420	-	1,420	959,889	141,462	1,101,351	4,499,350	922,580	5,421,930	-	-	-	-	-	-	-	-	-	-	-	-	5,460,659	1,064,042	6,524,701

5		**Primary Care**																							
	24	**Total Primary Care**	-	-	-	236,566	66,277	302,843	878,870	153,449	1,032,319			-			-			-			-	1,115,436	219,726	1,335,162
6		**Pharmacy**																							
	25	**Total Pharmacy**			-	560,457	63,013	623,470	2,500,130	482,738	2,982,868			-			-			-			-	3,060,587	545,750	3,606,337
7		**Medical/Surgical other than primary care**																							
	26	In-state	107	-	107	500,447	25,883	526,330	1,872,922	107,942	1,980,864			-			-			-			-	2,373,477	133,824	2,507,301
	27	Out-of-state	-	-	-	100,752	54,851	155,604	328,431	377,542	705,973			-			-			-			-	429,183	432,394	861,577
	28	**Total Other Medical/Surgical (Lines 26 + 27)**	107	-	107	601,200	80,734	681,934	2,201,353	485,484	2,686,837	-	-	-	-	-	-	-	-	-	-	-	-	2,802,660	566,218	3,368,878
8		**All other payments to medical providers**																							
	29	**Total**	133	-	133	240,951	41,780	282,732	1,082,028	206,290	1,288,317			-			-			-			-	1,323,112	248,070	1,571,182

2012 Rate Review Process
Areas of Medical Expense Variation

Introductory Remarks

The stated goal of this exercise is to improve OHIC's understanding of the drivers of rising medical spending in Rhode Island by comparing the experience of the issuer's Rhode Island member base to a benchmark. For the purposes of this analysis, we have used our 2011 fully insured MA HMO experience as the benchmark. However, given the size of Tufts Health Plan's membership base in Rhode Island, the results of this comparative analysis will have limited credibility. Our relative costs by area of care have changed significantly in Rhode Island from year to year and are expected to continue to be volatile as our population in this market grows. Although we have commented on the probable causes of each variation listed, these fundamentally reflect a small, immature market compared to a much larger, more mature benchmark and should be interpreted with caution.

1. The top five areas of care, based on *per capita total dollar value* positive variation from the benchmark

Area of Care	Total Excess Spending	PMPM Excess Spending	Comments on Estimated Cause
INPATIENT ACUTE MED/SURG	$1,339,638	$23.29	Attributable to higher utilization (both admits and ALOS), rather than unit cost. High cost claimants identified as having a disproportionately large impact. The higher number of admits may be a consequence of lower than benchmark outpatient professional care.
PHARMACY - Rx MM	$717,042	$12.46	Attributable to higher utilization across tiers and therapeutic classes. Higher utilization driven by more members in RI having prescriptions filled than in the benchmark population, rather than a higher number of prescriptions per member.
OUTPATIENT LABORATORY	$558,538	$9.71	Capitation strategy applied in the benchmark population successfully contains cost.
OUTPATIENT INJECTIONS	$425,609	$7.40	Driven primarily by a difference in payment methodology between RI and the benchmark population. Injection claims in RI are reimbursed on a fee for service basis while in the benchmark population they are reimbursed on a fee for service basis or bundled into an outpatient surgery case payment. More than 50% of the higher RI utilization is associated with outpatient surgery claims, which would not be separately identified in the benchmark population.
OUTPATIENT EMERGENCY ROOM	$406,508	$7.07	Attributable primarily to a higher cost per emergency room encounter. This higher cost per encounter is driven less by higher unit cost in RI and more by the higher number of services delivered within an emergency room encounter compared to the benchmark.

2. The top five areas of care, based on *the percent of positive variation in per capita spending* from the benchmark

Area of Care	Percent of Positive Variation	Total Excess Spending	Comments on Estimated Cause
OUTPATIENT INJECTIONS	158%	$425,609	Driven primarily by a difference in payment methodology as described above.
FREE STANDING HIGH COST RADIOLOGY (MRI, PET, CT)	124%	$130,764	Higher utilization of allied health facilities, along with lower Outpatient Hospital High Cost Radiology utilization, reflects appropriate re-direction of care to lower cost providers.
OUTPATIENT LABORATORY	96%	$558,538	Capitation strategy applied in the benchmark population successfully contains cost.
INPATIENT OTHER	74%	$117,886	Driven by Mental Health/Substance Abuse services. Capitation strategy for inpatient Mental Health/Substance Abuse within the benchmark population effective at containing costs.
OUTPATIENT EMERGENCY ROOM	63%	$406,508	Attributable primarily to the number of services delivered within an emergency room encounter, as described above.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Provider Contracting Practices and Hospital Contracting Conditions Verification Questionnaire

Background

The Health Insurance Advisory Council (HIAC) to the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) has promulgated Affordability Standards for commercial health insurance issuers in Rhode Island.

Health plans will improve the affordability of health care in Rhode Island by focusing their efforts upon provider payment reform, beginning with primary care. Achievement of this goal will not add to overall medical spend in the short-term, and is expected to produce savings thereafter. Specific areas of focus in support of this goal are as follows:

1. Expand and improve the primary care infrastructure in the state—with limitations on ability to pass on cost in premiums
2. Spread Adoption of the "Chronic Care Model" Medical Home
3. Standardize electronic medical record (EMR) incentives
4. Work toward comprehensive payment reform across the delivery system

To support standard four, OHIC has previously issued six conditions for issuer contracts with hospitals in Rhode Island, to be implemented by issuers upon contract execution, renewal, or extension. These are as follows:

1. Utilize unit of service payment methodologies for both inpatient and hospital outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee for service.
2. Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index ("Index"), for all contractual and optional years covered by the contract
3. Provide the opportunity for hospitals to increase their total annual revenue for

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

commercially insured enrollment under the contract by at least additional two percentage points over the previous contract year by improving or attaining mutually agreed-to performance levels for no less than three nationally-accepted clinical quality, service quality or efficiency-based measures.

4. Include terms that define the parties' mutual obligations for greater administrative efficiencies
5. Include terms that promote and measure improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers.
6. Include terms that explicitly relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement.

The purpose of this questionnaire is to assess compliance with standard four of the Affordability Standards and to consider the responses in connection with OHIC's 2012 small and large employer group rate factor review process for commercial health insurance issuers in Rhode Island.

Directions

1. Please fill out all parts of questionnaire.
2. As no providers are identified and no financial details are solicited, none of this information will be considered proprietary or confidential. Should any information or document be considered confidential by the filer, the filer must request approval of the Health Insurance Commissioner. The request must identify the specific information or document (or portion thereof) which the filer considers confidential, accompanied by a factual and legal analysis supporting the request.
3. Questionnaire responses must be verified by filing those portions of each hospital contract which support the survey response. An index or other method of reference must be included to identify which hospital contract documentation relates to each survey response. Any contract excerpts provided will be summarized for review.
4. Please contact OHIC with any questions.

State of Rhode Island Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920-4407
(401) 462-9640
(401) 462-9645 (Fax)
www.ohic.ri.gov
THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

General comment:

Tufts Health Plan has a long standing commitment to investment in payer-provider incentive alignment, and we maintain hospital and physician incentive programs that apply to the vast majority of our network providers. As a relatively new entrant into the RI market, we are at an early stage of incorporating incentive mechanisms into our RI provider contracts. Provider incentive will be a key component of our contracting strategy as we grow our presence in the state of RI.

Tufts Health Plan requests that the information provided in response to this survey be deemed to constitute "trade secrets" within the meaning of the term in section 38-2-2(4)(i)(B) of the Rhode Island General Laws. We have included a footer stating "THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION".

Finally, due to the questionable reliability of certain information provided in our responses, which is explained in further detail below, it is Tufts Health Plan's expectation and understanding that the information provided in this Provider Survey will not be used or considered in OHIC's review of Tufts Health Plan's rates.

Part 1. Hospital Inpatient Services

- **Please fill out one row in the chart below for <u>each</u> general service institution (no specialty care, no rehab) with whom you contract in RI.**
- **Institution means hospital system if all contractual terms other than $ amounts apply identically across all inpatient facilities in the contract.**
- **Incentives refer to activities or measures resulting in additional payments by the insurer.**

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments

[1] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[2] Attach analysis and relevant documentation from contracts to demonstrate compliance status.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
1	3 Years	X DRG X Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	No	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [3]	__ admission reductions __ day reductions __ process/structural changes (e.g. discharge practices) __Others (please specify)	N/A (Contract has not been renegotiated)	
2	3 Years	x DRG x Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.5~1.0%____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
3	3 Years	__DRG __Per Diem x % of Charges __ Bundled Services	No	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

[3] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
		__ Capitation or other budgeting __Others (please specify)		incentive payments. 0.1~0.5%			
4	2 Years	__DRG x Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
5	3 Years	__DRG __Per Diem x % of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	No	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
6	3 Years	__DRG __Per Diem x % of Charges __ Bundled	No	No If yes - % of total payments for inpatient services in CY	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
		Services __ Capitation or other budgeting __Others (please specify)		2011 spent on quality incentive payments. _____			
7	1 Year	__DRG _x_Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. ____ 0-2%	_X_ admission reductions _X_ day reductions __Others (please specify)	Yes, please see attached	
8	3 Years	__DRG _x_Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

Additional Questions for Hospital Inpatient Services

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

1. List the five most common areas of quality and service incentives in your company's inpatient contracts:
(These measures apply to our hospital contracts that combine inpatient and outpatient services.)
   i. Joint Commission measures (e.g., AMI, CHF, pneumonia)
   ii. Leapfrog measures (e.g., CPOD, ICU staffing)
   iii. Prevention of "Never Events"
   iv. Surgical infection rates
   v. Readmission rates
2. Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2011 spent on quality incentive payments. 0.1~1%

3. Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2011 paid through units of service based on efficient resource use (i.e DRG, Capitation, Bundled Service or partial/global budgeting): <5%

4. Estimated Payments in first six months of CY 2011 for Inpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: See comment (add comments or caveats)

   For inpatient services Tufts Health Plan does not currently have the technical capability to benchmark to Medicare IPPS reimbursement. Conducting such analysis would require incremental time, resources and technical capabilities. Benchmarking Tufts Health Plan inpatient payments to Medicare IPPS may yield volatile and potentially unreliable results due to a) differences in reimbursement methodology (Tufts Health Plan reimburses the majority of inpatient claims on either a Per Diem or Percent of Charge basis); b) our relatively small volume of business in Rhode Island; c) mix of services; and d) chargemaster levels to some of the hospitals in Rhode Island. Additionally, it is our belief that a Medicare comparison for some hospitals that perform very specific services, like Obstetrics, will not result in a comparison that is useful and may lead to unintended and/or misinterpreted conclusions.

Other Comments on Quality/Efficiency Incentives in Hospital Inpatient Contracting:

Part 2. Hospital Outpatient Services

- **Please fill out one row in the chart below for each general service institution (no specialty care, no rehab) with whom you contract in RI.**
- **Institution means hospital system if all contractual terms other than dollar amounts apply identically across all inpatient facilities in the contract.**
- **Outpatient Services include any services not involving an admission and covered under the contract with the institution.**

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[4]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - %of total payments for inpatient services in CY 2011 spent on quality incentive payments. [5]	__ Visit/Volume Reduction __ Others (please specify)	
2	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.5~1.0%____	__ Visit/Volume Reduction __ Others (please specify)	
3	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.1~0.5%	__ Visit/Volume Reduction __ Others (please specify)	
4	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality	__ Visit/Volume Reduction __ Others (please specify)	

[4] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[5] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[4]?	Utilization Incentives in Contract: (check all that apply)	Comments
		incentive payments. _____		
5	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
6	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
7	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
8	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	

Additional Questions for Hospital Outpatient Services

1. List the five most common areas of quality and service incentives in your company's hospital outpatient contracts:

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

(These measures apply to our hospital contracts that combine inpatient and outpatient services.)

i. Joint Commission measures (e.g., AMI, CHF, pneumonia)
ii. Leapfrog measures (e.g., CPOD, ICU staffing)
iii. Prevention of "Never Events"
iv. Surgical infection rates
v. Readmission rates

2. Percent of total payments to RI Hospitals for outpatient services in CY 2011 spent on quality incentive payments. 0.1~1%

3. Percent of total payments to RI Hospitals for outpatient services in CY 2011 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): n/a

4. Estimated Payments in first six months of CY 2011 for Outpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: 222% (i.e. 122% over Medicare Reimbursement) (add comments or caveats)

   For Outpatient Services, Tufts Health Plan has the technical capabilities to perform the required benchmarking analysis to Medicare; however, we have concerns about the confidence level in the accuracy of the supplied benchmark. Our concerns are due to a) the allowed reimbursement at a claim level was compared to fee information obtained from OPPS and CMS ancillary schedules such as Clinical Lab, DME etc.; b) we are not able to reprocess our claims through an OPPS Grouper and were limited to a line level reprice based on OPPS/Ancillary fees which means that exact Medicare reimbursement can only be approximated; c) Procedures that do not have a fee on OPPS/Ancillary schedules, or are billed in a different manner to Medicare (e.g., observation) were dropped from the analysis.

   Additionally, Tufts Health Plan has concerns that the results may be skewed due to a few high-volume hospitals and the large number of providers reimbursed on a percent of charges basis – factors that may distort the data due to particular mix of services and chargemaster levels of PAF providers. Based on the concerns listed above it is our belief that a Medicare comparison might not result in a benchmark that is useful and could lead to unintended and/or misinterpreted conclusions that if made public could impact certain contract negotiations by putting upward pressure on unit costs.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Other Comments on Quality/Efficiency Incentives in Hospital Outpatient Contracting:

Part 3: Professional Groups

- **"Professional Groups" is defined as non institutional/non facility groups with a valid contract and a single tax id number.**
- **Please provide information for the top 10 groups (measured by $ paid in 2011), filling in one row per group (10 rows in the table total).**

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	Multi-specialty	x Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [7] _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services _ Others (please specify)	
2	Multi-specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
3	Multi-specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code	No If yes - % of total payments for inpatient services in CY 2011 spent	__Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care	

[6] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[7] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
		__ Full/ Partial Capitation __Other (please specify)	on quality incentive payments. _____	__ use of pharmacy services __ Others (please specify)	
4	Sub - Specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
5	Primary Care	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
6	Primary Care	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0~5%	x Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care x use of pharmacy services x Others (please specify)	Quality/Member Satisfaction
7	Sub - Specialty	_ X _ Procedure-based methodology – using CPT, plan,	No	__ Visit/Volume Reduction __use of ancillary/referred services	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
		provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments.	__ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
8	Sub - Specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
9	Multi-specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
10	Multi-specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Additional Questions for Professional Groups

1. List the five most common areas of quality and service incentives in your company's professional group contracts:
   i. HEDIS (diabetes, breast cancer screening, colonoscopy, etc.)
   ii. HCHAPS
   iii. EMR adoption
   iv. Inpatient and ER use
   v. Rx Management
2. Percent of total payments to these ten professional groups in CY 2011 spent on quality incentive payments. ___<1%_____

3. Percent of total payments to these ten professional groups in CY 2011 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): ___n/a_____

4. Estimated Payments in first six months of CY 2011 for Professional Group Services as % of what Medicare would have paid for similar set. of services: 122% (i.e. 22% over Medicare Reimbursement) (add comments or caveats)

   The analysis was conducted using a claim line level comparison between allowed reimbursement and Medicare fee information obtained from RBRVS tables as well as Medicare ancillary schedules such as clinical lab, DME etc. Anesthesia services were also included. Procedures that Medicare does not reimburse but supplies RVU information for, such as preventive medicine and consults codes, are included at the RVU level rate for the Medicare comparison. Claims lines that do not have RBRVS/Ancillary schedule information were dropped from the analysis.

   Additionally, Tufts Health Plan has concerns that the results may be skewed due to particular mix of services for providers. Based on the concerns listed above it is our belief that a Medicare comparison might not result in a benchmark that is useful and could lead to unintended and/or misinterpreted conclusions that if made public could impact certain contract negotiations by putting upward pressure on unit costs.

Other Comments on Quality/Efficiency Incentives in Professional Group Contracting:

Selected Contract Sections Showing Compliance To OHIC Conditions

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Effective for dates of service on or after January 1, 2011

Office of the Health Insurance Commissioner Conditions

Pay-For-Performance: **[Redacted]** is available for the Hospital to earn based upon quality and/or efficiency measures **[redacted]**.

Case Rates: In the event **[redacted]** parties agree to meet to discuss the potential to transition to efficiency based payment methodologies (e.g., DRG, APC) in a manner that **[redacted]**.

Administrative Efficiency: Tufts Health Plan agrees to assign a Contract Specialist to provide ongoing contract related support through the term of the agreement to help mitigate contract related issues.

The Hospital agrees to work with and communicate issues to the Contract Specialist on an ongoing basis and work in good faith to resolve contract related issues in a timely manner.

Communication: During calendar year 2011 parties agree to formalize clinical communication that promotes and measures improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers.

Public Release of Contract Terms: Parties agree to allow the public release of terms outlined in this agreement if compelled by State regulatory authorities.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

1. Please provide an excel spreadsheet in the following format, detailing the 2011 actual and 2013 requested small and large group administrative costs pmpm, allocated among the NAIC- financial statement administrative cost categories. Please explain any significant changes from the financial filing for 2011 (increases/decreases of more than five percent in a particular category).

RI Insured PPO	2011 Actual (from filed financial statements)		2013 Proposed		% Change	
	Small Group	Large Group	Small Group	Large Group	Small Group	Large Group
Total Estimated Member Months	6,778	28,008	5,732	26,480	-15.4%	-5.5%
Total Estimated Premiums ($pmpm)	$382.46	$404.51	$425.43	$449.88	11.2%	11.2%
Total General Administrative Expense	$37.84	$37.94	$45.37	$43.14	19.9%	13.7%
Total Cost Containment Expense	$10.43	$9.64	$11.73	$11.73	12.5%	21.7%
Total Other Claim Adjustment Expense ($pmpm)	$7.99	$7.38	$8.98	$8.98	12.5%	21.7%
Breakdown of General Administrative Expense ($pmpm)						
a. Payroll and benefits	$2.94	$2.72	$3.31	$3.31	12.5%	21.7%
b. Outsourced Services (EDP, claims etc.)	$0.09	$0.09	$0.10	$0.10	12.5%	21.7%
c. Auditing and consulting	$8.02	$7.42	$9.03	$9.03	12.5%	21.7%
d. Commissions	$13.32	$14.30	$14.35	$12.12	7.7%	-15.2%
e. Marketing and Advertising	$1.76	$1.63	$1.98	$1.98	12.5%	21.7%
f. Legal Expenses	$0.17	$0.16	$0.19	$0.19	12.5%	21.7%
g. Taxes, Licenses and Fees	$8.72	$9.22	$13.43	$13.43	54.0%	45.6%
h. Reimbursements by Uninsured Plans	$0.00	$0.00	$0.00	$0.00	0.0%	0.0%
i. Other Admin Expenses	$2.82	$2.42	$2.99	$2.99	6.1%	23.6%

Notes

1. The expense in any given administrative category may vary from year to year due to the small size of Tufts Health Plan's PPO block of business in Rhode Island. In aggregate, however, total admin has increased less than about 3% per year.

2. Please also provide an excel spreadsheet in the following format; detailing actual calendar year 2007-2011 fully insured commercial administrative costs, in accordance with the following table. This should be consistent with the annual statement filings to OHIC for administrative costs, providing additional detail on the components of administrative costs using the categories defined by NAIC financial statement and as allocated to commercially insured business only. Specifically, the information provided should agree with the "Exhibit of Premiums, Enrollment and Utilization" and the "Analysis of Operations by Line of Business" schedules included in the Annual Statements on file with OHIC. Where there are variance, a reconciliation and explanation should be provided.

Fully Insured Commercial Administrative Cost History

RI Insured PPO	2007	2008	2009	2010	2011
Total Premiums			12,373,810	17,393,107	13,921,729
Total General Administrative Expense			1,929,424	1,887,787	1,319,190
General Admin Exp. Ratio			15.6%	10.9%	9.5%
Total Fully Insured Member Months			33,738	45,416	34,786
General Administrative Expense ($pmpm)			$57.19	$41.57	$37.92
Breakdown of General Administrative Expense ($pmpm)					
a. Payroll and benefits			$3.37	$2.49	$2.76
b. Outsourced Services (EDP, claims etc.)			$0.01	$0.01	$0.09
c. Auditing and consulting			$5.92	$4.93	$7.54
d. Commissions			$18.10	$16.49	$14.11
e. Marketing and Advertising			$2.52	$1.72	$1.66
f. Legal Expenses			$0.08	$0.11	$0.16
g. Taxes, Licenses and Fees			$7.34	$8.74	$9.12
h. Reimbursements by Uninsured Plans			$0.00	$0.00	$0.00
i. Other Admin Expenses			$19.85	$7.09	$2.50
Cost Containment Expense			179,767	385,924	340,764
Other Claim Adjustment Expense			236,579	369,709	260,894
Total Self Insured Member Months for all Affiliated Companies doing business in RI			113,694	0	662

RI Insured PPO

3. At the request of OHIC's Health Insurance Advisory Council, please provide brief answers to the following questions

- **In general and net of new taxes and fees, why should the rate of increase in Health Plan administrative costs exceed the general inflation rate?**

  Administrative expenses in total in a given year are adjusted for inflation, membership growth or loss and increases or decreases in corporate projects, which are often driven by regulatory requirements and government mandates. As a general practice, to set administrative expense targets for the annual financial plan, fixed administrative costs are grown at an inflationary rate. Variable administrative costs are then developed by applying inflation to the variable pmpm rate and then multiplying the inflated pmpm rate by planned member months. While those are the initial steps to develop targets, each administrative function is reviewed in detail to identify potential administrative cost savings and targets are adjusted accordingly.

- **What percentage of administrative costs does your organization consider fixed for the next five years? Provide detail by expense categories.**

  For the total company, we currently consider 58% of our costs fixed as follows:

Fixed Administrative Costs by Category:	
Network Management	2%
Sales and Marketing	4%
Clinical Services	5%
Operations	5%
IT & Business Effectiveness	8%
Corporate Projects	14%
Fixed Overhead and Other	20%
Total Fixed Administrative Expenses	58%

- **What administrative services are used by fully insured members that are not used by self-insured clients (e.g. broker commissions) and what are the estimated total costs ($pmpm) for those services?**

  Administrative costs for fully insured membership include expenses associated with medical cost containment ($9.80 pmpm), whereas in most cases self-insured clients bear these costs directly. Broker commissions ($14.11 pmpm) are also not applicable to most self-insured clients.

- **What does your plan use as its pmpm benchmarks or price points for commercial insurance administrative costs and why?**

We periodically participate in the benchmarking survey used to develop the *Sherlock Expense Evaluation Reports* (SEER) which are viewed as the definitive benchmarks for the functional areas of health plan administration. The Sherlock Expense Evaluation Reports (SEER) supply comprehensive and highly granular financial and operational metrics.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Health System Improvements Survey

The State of Rhode Island Office of the Health Insurance Commissioner Regulation 2 lists standards to be used by the Health Insurance Commissioner (Commissioner) for the assessment of the conduct of commercial health insurance issuers in Rhode Island for their efforts aimed at improving the efficiency and quality of health care delivery and increasing access to health care services. The standards include the following issuer activities:

1. Directing resources, including financial contributions, toward system-wide improvements in the state's health care system related to quality, access and efficiency, including providing support to local collaboratives, organizations, and initiatives that promote these three goals

2. Participating in the development and implementation of public policy issues related to health

To assist the Commissioner in this assessment, as part of the 2012 small and large employer group rate factor review process for commercial health insurance issuers in Rhode Island, please itemize and quantify your organization's contributions of finances and other material assets to these efforts in Rhode Island in calendar year 2011 in the following table.[1]

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
Funding	Grants provided by the Tufts Health Plan Foundation and Community Relations to the following RI organizations to support wellness and safety initiatives • **Best Buddies International** *Best Buddies Intergenerational College Project* Grant Amount: $20,000 • **Mount St. Rita Health Centre** *Blessings in a Back Pack* Grant Amount: $5,000 • **Bethany Home of Rhode Island Inc.**	**$515,724**

[1] The contributions can be to any entity other than a provider to improve medical and prevention services for all Rhode Islanders and to promote a coherent, integrated, and efficient statewide health care system.

State of Rhode Island Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920-4407
(401) 462-9640
(401) 462-9645 (Fax)
www.ohic.ri.gov

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
	Bethany Home Cares Grant Amount: $43,036 • **Homefront Health Care** *HIP-SAFE (Homefront Intervention to Prevent Slips & Falls in Elders)* Grant Amount: $59,438 • **Rhode Island Free Clinic Inc.** *Healthy Lifestyles for Today and Tomorrow* Grant Amount: $60,000 • **The Providence Center** *InShape Seniors* Grant Amount: $42,000 • **Ocean State Center for Independent Living (OSCIL)** *Home Sweet Accessible Home* Grant Amount: $40,000 • **Westbay Community Action Inc.** *Elder Safety* Grant Amount: $42,000 • **Rhode Island Quality Institute** *Health Information Exchange Support* Grant Amount: $25,000 • **EMR Payments** $179,250	

Participation in RI initiatives, programs and organizations	The goals of these programs, initiatives and organizations is to improve quality and/or transform primary care in the state:
	• CSI/Beacon (Project director, project manager, and nurse case manager support) $38,329
	• Value of Resource Time in Various Programs (Estimate of $30,000 for 0.2 FTE for 2011)
	  ○ RI DOH Medical Director meetings
	  ○ RI Quality Partners Safe Transitions
	  ○ RI Senate Commission on Hospital Payment Reform
	  ○ RIQI Board of Directors
	  ○ RI CSI Beacon Executive Committee
		$68,329

Thank you for your cooperation.

Tufts Insurance Company

Large Group Rate Filing -- Effective Date January 1, 201

Part 1. Historical Information

Experience Period for Developing Rates	
From	To
01/01/2009	12/31/2011

Utilization/Experience Data by Quarter (Last 12 Available Quarters)

Quarter	End Date	IP Days	Member Months	Earned Premium	Incurred Claims Total	Incurred Claims IP	Incurred Claims OP	Incurred Claims Primary Care	Incurred Claims Other M/S	Incurred Claims Rx	Loss Ratio	Quality Improvement Expense*	Other Cost Containment Expense*	Other Claim Adjustment Expense*	Other Operating Expense*	Investment Income Credit	Commissions	Contribution to Reserves
1 (Oldest)	03/31/2009	82	2,357	$895,234	$778,094	$167,486	$266,832	$42,046	$188,476	$113,254	88.9%	$17,395	$10,077	$13,183	$79,159	N/A	$37,942	($40,615)
2	06/30/2009	138	4,984	$1,886,389	$1,428,578	$305,927	$382,248	$98,764	$365,250	$276,390	77.7%	$36,783	$21,309	$27,876	$167,386	N/A	$80,230	$124,227
3	09/30/2009	155	6,727	$2,578,593	$2,534,421	$946,384	$554,008	$120,535	$532,806	$380,690	100.2%	$49,647	$28,762	$37,625	$225,924	N/A	$108,288	($406,074)
4	12/31/2009	199	7,532	$2,856,684	$2,493,403	$480,304	$619,165	$149,673	$763,475	$480,786	89.2%	$55,189	$31,973	$41,826	$251,526	N/A	$120,377	($137,609)
5	03/31/2010	267	9,113	$3,524,916	$3,133,741	$881,025	$716,794	$180,987	$838,087	$516,848	90.8%	$65,248	$30,966	$40,509	$235,871	N/A	$140,525	($121,943)
6	06/30/2010	138	8,349	$3,238,492	$2,462,532	$388,858	$691,211	$155,553	$749,782	$477,128	77.9%	$59,789	$28,375	$37,119	$216,122	N/A	$128,767	$305,789
7	09/30/2010	175	8,310	$3,350,598	$2,633,548	$515,443	$660,800	$167,904	$777,512	$511,888	80.4%	$59,623	$28,296	$37,017	$215,385	N/A	$128,410	$248,319
8	12/31/2010	132	8,441	$3,427,920	$2,898,658	$553,078	$761,074	$178,201	$877,069	$529,237	86.3%	$60,544	$28,733	$37,588	$218,734	N/A	$130,393	$53,268
9	03/31/2011	152	7,667	$3,132,702	$2,649,905	$527,237	$755,459	$144,295	$766,889	$456,025	86.2%	$49,674	$31,249	$38,226	$191,980	N/A	$109,362	$62,306
10	06/30/2011	103	7,107	$2,918,613	$2,292,577	$311,627	$678,477	$146,187	$680,221	$476,065	80.1%	$46,046	$28,966	$35,434	$177,958	N/A	$101,374	$236,259
11	09/30/2011	173	6,677	$2,680,582	$2,663,871	$587,051	$728,870	$135,681	$751,308	$460,960	101.0%	$43,260	$27,214	$33,290	$167,191	N/A	$95,241	($349,484)
12	12/31/2011	132	6,620	$2,653,346	$2,408,236	$371,964	$657,269	$154,051	$759,233	$465,719	92.4%	$42,890	$26,981	$33,006	$165,764	N/A	$94,428	($117,959)

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3- Analysis of Expenses and/or to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1

If any of the historical information reported is different from that period as reported in the prior rate filing, please provide a reconciliation and explanation showing the amount of each element of difference.

Notes:
1. The Other Operating Expenses shown above include taxes, licenses and fees, which were excluded in previous filings for the same time periods
2. Primary care claims definition has been revised to match the Primary Care Spend report
3. Expenses such as network access fee, COB and claims interest are moved from Other M/S claims to administrative expenses according to NAIC definition
4. Claims Total differences from the previous filings for the same time periods are due to updated IBNR factors that reflect more up to date claims payment, as well as the revision to the Other M/S claims definition
5. Loss ratio is calculated as (Incurred Claims Total + Quality Improvement Expense) / Earned Premium

Part 2. Prospective Information

A. 2013 Trend Factors for Projection Purposes (Annualized)

	IP	OP	Primary Care	Other M/S	Rx	Weighted Total
Total	5.2%	6.7%	5.4%	4.7%	4.7%	5.4%
Price Only	3.6%	3.4%	3.3%	1.8%	0.8%	2.6%
Utilization	1.5%	3.2%	2.0%	2.9%	3.9%	2.8%
Other**						
Other**						
Other**						
Weights	20.4%	26.5%	9.4%	26.3%	17.4%	100%

** All elements should add or compound to the total. If anything is to be reported as "Other" please provide a description.

2012 Trend Factors for Projection Purposes (Annualized)

	IP	OP	Primary Care	Other M/S	Autism Mandate	Rx	Weighted Total
Total	5.9%	7.6%	6.4%	4.8%	0.2%	0.3%	5.3%
Price Only	3.6%	3.7%	4.1%	1.3%		-3.6%	1.9%
Utilization	2.2%	3.8%	2.2%	3.5%		4.0%	3.3%
Other**							
Other**							
Other**							
Weights	20.2%	24.7%	8.4%	29.3%		17.4%	100%

** All elements should add or compound to the total. If anything is to be reported as "Other" please provide a description.

B. The following items for the period to which the rate filing applies, by quarter:

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %
1	01/01/2013	6.1%	86.4%	0.0%	1.6%	1.1%	1.4%	4.5%	2.7%	0.0%	2.3%
2	04/01/2013	5.8%	86.4%	0.0%	1.6%	1.1%	1.4%	4.5%	2.7%	0.0%	2.3%

3	07/01/2013	5.9%	86.4%	0.0%	1.6%	1.1%	1.4%	4.5%	2.7%	0.0%	2.3%
4	10/01/2013	6.1%	86.4%	0.0%	1.6%	1.1%	1.4%	4.5%	2.7%	0.0%	2.3%
Weighted Average		6.0%	86.4%	0.0%	1.6%	1.1%	1.4%	4.5%	2.7%	0.0%	2.3%

Quarter	Beginning Date	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %
1	01/01/2012	3.4%	87.0%	0.0%	1.1%	0.8%	1.1%	5.0%	2.7%	0.0%	2.3%
2	04/01/2012	3.0%	87.0%	0.0%	1.1%	0.8%	1.1%	5.0%	2.7%	0.0%	2.3%
3	07/01/2012	4.0%	87.0%	0.0%	1.1%	0.8%	1.1%	5.0%	2.7%	0.0%	2.3%
4	10/01/2012	6.6%	87.0%	0.0%	1.1%	0.8%	1.1%	5.0%	2.7%	0.0%	2.3%
Weighted Average		4.2%	87.0%	0.0%	1.1%	0.8%	1.1%	5.0%	2.7%	0.0%	2.3%

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3 - Analysis of Expenses and to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1
The sum of the expenses, commissions, contributions to reserves, investment income credit, taxes and the medical loss ratio should be 100%.

C. Average Rate Increase Components

The following items should reconcile to the Weighted Average Percent Rate Increase for the year:

	Price	Utilization, Mix	Total
Hospital Inpatient Price	0.6%	0.3%	0.9%
Hospital Outpatient	0.8%	0.7%	1.5%
Primary Care	0.3%	0.2%	0.4%
Med/Surg Other Than Primary Care	0.4%	0.7%	1.1%
Pharmacy	0.1%	0.6%	0.7%
Administrative Expense (Aggregated)			0.6%
Contribution to Reserves			0.0%
Taxes and Assessments			0.2%
Legally Mandated Changes			0.0%
Prior Period Adjustment (+/-)			0.6%
Total			6.0%

Note:
1. Due to the lack of credible experience, manual rates are developed by trending forward prior base rates to reflect trend changes. Therefore, depending on the timing of trend change, rate increases may be different from trend increase. The difference is reflected as Prior Period Adjustment above.

Part 3. Retrospective Reconciliation of Experience with Filed Factors

	Filed Data[1]					PMPM Increase[2]		Standard Plan PMPM[3]		Standard Plan Increase[4]		Approved		Loss Ratio	
Year	Member Months	Earned Premium	Incurred Claims Total	Premium PMPM	Claims PMPM	Premium	Claims	Premium	Claims	Premium	Claims	Trend Increase%	Contrib to Reserves%	Actual%	Filed%
2009	21,600	8,216,900	7,393,509	$380.41	$342.29			-	-			9.7%	0%	90.0%	87.0%
2010	34,213	13,541,926	11,373,683	$395.81	$332.44	4.0%	-2.9%	370.55	341.89	N/A	N/A	9.3%	0%	84.0%	87.0%
2011	28,071	11,385,244	10,196,459	$405.59	$363.24	2.5%	9.3%	-	-	N/A	N/A	9.2%	0%	89.6%	88.1%

[1] Corresponds to historical Information data in Part 1 above
[2] Percent increase compared to prior year
[3] For most commonly held plan of benefits in 2010 and for the same plan of benefits in 2011
Note that the most commonly held plan of benefits in 2010 was not held by any plan in either 2009 or 2011
[4] Percent increase compared to prior year
Note:
1. Filed loss ratio for CY 2011 is the sum of the expected pure medical cost ratio and expected quality improvement expenses % in 2011 rate factor filing

Rhode Island Health Statement Supplement

Cover Sheet

Company Name	**Tufts Associated Health Maintenance Organizations & Tufts Insurance Company**		
Enter NAIC#	**95688 & 60177**	**Reporting Year**	**2011**
Enter DBR registration # (TPAs)			

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Office of the Health Insurance Commissioner
1511 Pontiac Ave, Building #69 first floor
Cranston, RI 02920
(401) 462-9517
(401) 462-9645 (fax)
HealthInsInquiry@ohic.ri.gov

Line of Business Exhibit

Field			1 Comprehensive/Major medical			2 ASO/TPA			3 Stop loss/ Excess loss/Reinsurance			4 Medicare Part C			5 Medicare Part D			6 Medicare Supplement Policies			7 Medicaid/Other public			8 Student blanket			9 Dental Only			10 Other Medical Non-Comprehensive			11 Total (Across all lines of business)		
			RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
1		**Membership Data**																																
		Number of Polices or Certificates	197	-	197	1	-	1			-			-	91		91	3	-	3			-			-			-			-	292	-	292
		Number of Covered Lives	3,936	737	4,673	299	29	328			-			-	91		91	5	-	5			-			-			-			-	4,331	766	5,097
		Member Months	48,618	8,909	57,527	603	59	662			-			-	1,062		1,062	60	-	60			-			-			-			-	50,343	8,968	59,311
		Number of Polices or Certificates (**Plans with PD benefits**)	197	-	197	1	-	1	-	-	-	-	-	-	91	-	91	3	-	3	-	-	-	-	-	-	-	-	-	-	-	-	292	-	292
		Number of Covered Lives (**Plans with PD benefits**)	3,936	737	4,673	299	29	328	-	-	-	-	-	-	91	-	91	5	-	5	-	-	-	-	-	-	-	-	-	-	-	-	4,331	766	5,097
		Member Months (**Plans with PD benefits**)	48,618	8,909	57,527	603	59	662	-	-	-	-	-	-	1,062	-	1,062	60	-	60	-	-	-	-	-	-	-	-	-	-	-	-	50,343	8,968	59,311
2		**Premiums/Claims**																																
		Premium	19,382,569	3,553,785	22,936,354	162,614	18,088	180,702			-			-	146,221		146,221	23,160	-	23,160			-			-			-			-	19,714,564	3,571,873	23,286,437
		Claims/Medical Expenses	17,496,249	3,228,233	20,724,482	139,151	15,072	154,222			-			-	405,690		405,690	20,052	-	20,052			-			-			-			-	18,061,142	3,243,305	21,304,446
3		**Inpatient Facility**																																
		Hospital																																
	1	In-state	3,158,748	206,043	3,364,791	17,550	-	17,550			-			-			-	-	-	-			-			-			-			-	3,176,298	206,043	3,382,341
	2	Out-of-state	540,726	359,998	900,724	-	-	-			-			-			-	-	-	-			-			-			-			-	540,726	359,998	900,724
	3	Total (Lines 1 + 2)	3,699,474	566,041	4,265,515	17,550	-	17,550	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3,717,024	566,041	4,283,065
		SNF																																
	4	In-state	33,154	5,624	38,778	-	-	-			-			-			-	-	-	-			-			-			-			-	33,154	5,624	38,778
	5	Out-of-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	6	Total (Lines 4 + 5)	33,154	5,624	38,778	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	33,154	5,624	38,778
		Other																																
	7	In-state	1,167	-	1,167	-	-	-			-			-			-	-	-	-			-			-			-			-	1,167	-	1,167
	8	Out-of-state	-	12,761	12,761	-	-	-			-			-			-	-	-	-			-			-			-			-	-	12,761	12,761
	9	Total (Lines 7 + 8)	1,167	12,761	13,928	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,167	12,761	13,928
	10	**Total Inpatient Facility (Lines 3 + 6 + 9)**	3,733,795	584,427	4,318,222	17,550	-	17,550	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3,751,345	584,427	4,335,772
4		**Outpatient Facility**																																
		Hospital																																
	11	In-state	3,352,396	210,704	3,563,100	22,675	916	23,591			-			-			-	1,633	-	1,633			-			-			-			-	3,376,704	211,620	3,588,324
	12	Out-of-state	317,396	538,951	856,347	1,088	1,834	2,922			-			-			-	-	-	-			-			-			-			-	318,484	540,785	859,269
	13	Total (Lines 11 + 12)	3,669,791	749,655	4,419,447	23,763	2,749	26,512	-	-	-	-	-	-	-	-	-	1,633	-	1,633	-	-	-	-	-	-	-	-	-	-	-	-	3,695,188	752,404	4,447,593
		SNF																																
	14	In-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	15	Out-of-state	-	-	-	-	-	-			-			-			-	-	-	-			-			-			-			-	-	-	-
	16	Total (Lines 14 + 15)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
		Freestanding Ambulatory Care Facility																																
	17	In-state	747,250	53,967	801,218	1,893	-	1,893			-			-			-	-	-	-			-			-			-			-	749,143	53,967	803,110
	18	Out-of-state	168,850	101,890	270,740	-	4,631	4,631			-			-			-	-	-	-			-			-			-			-	168,850	106,521	275,371
	19	Total (Lines 17 +18)	916,100	155,858	1,071,958	1,893	4,631	6,524	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	917,993	160,489	1,078,482
		Other																																
	20	In-state	728,426	17,731	746,156	2,074	115	2,189			-			-			-	310	-	310			-			-			-			-	730,809	17,845	748,655
	21	Out-of-state	146,342	140,799	287,140	945	369	1,314			-			-			-	47	-	47			-			-			-			-	147,334	141,167	288,501
	22	Total (Lines 20 + 21)	874,767	158,529	1,033,296	3,019	484	3,503	-	-	-	-	-	-	-	-	-	357	-	357	-	-	-	-	-	-	-	-	-	-	-	-	878,143	159,013	1,037,156
	23	**Total Outpatient Facility (Lines 13 + 16 + 19 + 22)**	5,460,659	1,064,042	6,524,701	28,676	7,864	36,539	-	-	-	-	-	-	-	-	-	1,990	-	1,990	-	-	-	-	-	-	-	-	-	-	-	-	5,491,325	1,071,906	6,563,231
5		**Primary Care**																																
	24	**Total Primary Care**	1,115,436	219,726	1,335,162	15,201	842	16,043			-			-			-	679	-	679			-			-			-			-	1,131,316	220,567	1,351,883
6		**Pharmacy**																																
	25	**Total Pharmacy**	3,060,587	545,750	3,606,337	44,737	1,491	46,227			-			-	405,690		405,690	10,316	-	10,316			-			-			-			-	3,521,330	547,241	4,068,570
7		**Medical/Surgical other than primary care**																																
	26	In-state	2,373,477	133,824	2,507,301	17,385	1,341	18,726			-			-			-	5,354	-	5,354			-			-			-			-	2,396,216	135,165	2,531,381
	27	Out-of-state	429,183	432,394	861,577	442	1,815	2,257			-			-			-	-	-	-			-			-			-			-	429,625	434,208	863,834
	28	**Total Other Medical/Surgical (Lines 26 + 27)**	2,802,660	566,218	3,368,878	17,828	3,155	20,983	-	-	-	-	-	-	-	-	-	5,354	-	5,354	-	-	-	-	-	-	-	-	-	-	-	-	2,825,841	569,374	3,395,215
8		**All other payments to medical providers**																																
	29	**Total**	1,323,112	248,070	1,571,182	15,159	1,720	16,880			-			-			-	1,714	-	1,714			-			-			-			-	1,339,986	249,790	1,589,776

Field	Market Exhibit (For Comprehensive/Major Medical Line of Business)	1 Individual			2 Small Group			3 Large Group			4 Association			5 Trust			6 Federal Employee Health Benefit Plan			7 Other Health Market			8 Total (Across all markets)		
		RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All	RI	Non-RI	All
	Membership Data																								
	Number of Polices or Certificates	1	-	1	165	-	165	31	-	31			-			-			-			-	197	-	197
	Number of Covered Lives	1	-	1	702	140	842	3,233	597	3,830			-			-			-			-	3,936	737	4,673
1	Member Months	12	-	12	9,473	1,838	11,311	39,133	7,071	46,204			-			-			-			-	48,618	8,909	57,527
	Number of Polices or Certificates (**Plans with PD benefits**)	1	-	1	165	-	165	31	-	31	-	-	-	-	-	-	-	-	-	-	-	-	197	-	197
	Number of Covered Lives (**Plans with PD benefits**)	1	-	1	702	140	842	3,233	597	3,830	-	-	-	-	-	-	-	-	-	-	-	-	3,936	737	4,673
	Member Months (**Plans with PD benefits**)	12	-	12	9,473	1,838	11,311	39,133	7,071	46,204	-	-	-	-	-	-	-	-	-	-	-	-	48,618	8,909	57,527
	Premiums/Claims																								
2	Premium	2,874	-	2,874	3,658,257	690,328	4,348,585	15,721,439	2,863,457	18,584,896			-			-			-			-	19,382,569	3,553,785	22,936,354
	Claims/Medical Expenses	1,660	-	1,660	3,100,638	454,637	3,555,275	14,393,951	2,773,596	17,167,547			-			-			-			-	17,496,249	3,228,233	20,724,482
	Inpatient Facility																								
	Hospital																								
1	In-state	-	-	-	441,217	49,217	490,434	2,717,530	156,826	2,874,356			-			-			-			-	3,158,748	206,043	3,364,791
2	Out-of-state	-	-	-	52,816	12,154	64,969	487,911	347,844	835,755			-			-			-			-	540,726	359,998	900,724
3	Total (Lines 1 + 2)	-	-	-	494,033	61,371	555,404	3,205,441	504,670	3,710,111	-	-	-	-	-	-	-	-	-	-	-	-	3,699,474	566,041	4,265,515
	SNF																								
3 4	In-state	-	-	-	7,542	-	7,542	25,612	5,624	31,236			-			-			-			-	33,154	5,624	38,778
5	Out-of-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
6	Total (Lines 4 + 5)	-	-	-	7,542	-	7,542	25,612	5,624	31,236	-	-	-	-	-	-	-	-	-	-	-	-	33,154	5,624	38,778
	Other																								
7	In-state	-	-	-	-	-	-	1,167	-	1,167			-			-			-			-	1,167	-	1,167
8	Out-of-state	-	-	-	-	-	-	-	12,761	12,761			-			-			-			-	-	12,761	12,761
9	Total (Lines 7 + 8)	-	-	-	-	-	-	1,167	12,761	13,928	-	-	-	-	-	-	-	-	-	-	-	-	1,167	12,761	13,928
10	**Total Inpatient Facility (Lines 3 + 6 + 9)**	-	-	-	501,575	61,371	562,946	3,232,220	523,056	3,755,276	-	-	-	-	-	-	-	-	-	-	-	-	3,733,795	584,427	4,318,222
	Outpatient Facility																								
	Hospital																								
11	In-state	-	-	-	514,964	32,443	547,407	2,837,431	178,261	3,015,692			-			-			-			-	3,352,396	210,704	3,563,100
12	Out-of-state	-	-	-	117,047	54,151	171,198	200,349	484,800	685,149			-			-			-			-	317,396	538,951	856,347
13	Total (Lines 11 + 12)	-	-	-	632,011	86,594	718,605	3,037,780	663,061	3,700,842	-	-	-	-	-	-	-	-	-	-	-	-	3,669,791	749,655	4,419,447
	SNF																								
14	In-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
15	Out-of-state	-	-	-	-	-	-	-	-	-			-			-			-			-	-	-	-
4 16	Total (Lines 14 + 15)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Freestanding Ambulatory Care Facility																								
17	In-state	-	-	-	160,253	5,262	165,515	586,997	48,705	635,702			-			-			-			-	747,250	53,967	801,218
18	Out-of-state	-	-	-	42,588	11,594	54,182	126,262	90,297	216,558			-			-			-			-	168,850	101,890	270,740
19	Total (Lines 17 + 18)	-	-	-	202,841	16,856	219,698	713,259	139,002	852,260	-	-	-	-	-	-	-	-	-	-	-	-	916,100	155,858	1,071,958
	Other																								
20	In-state	1,420	-	1,420	109,081	7,179	116,260	617,925	10,551	628,476			-			-			-			-	728,426	17,731	746,156
21	Out-of-state	-	-	-	15,956	30,833	46,788	130,386	109,966	240,352			-			-			-			-	146,342	140,799	287,140
22	Total (Lines 20 + 21)	1,420	-	1,420	125,037	38,012	163,048	748,311	120,517	868,828	-	-	-	-	-	-	-	-	-	-	-	-	874,767	158,529	1,033,296
23	**Total Outpatient Facility (Lines 13 + 16 + 19 + 22)**	1,420	-	1,420	959,889	141,462	1,101,351	4,499,350	922,580	5,421,930	-	-	-	-	-	-	-	-	-	-	-	-	5,460,659	1,064,042	6,524,701

5		**Primary Care**																							
	24	**Total Primary Care**	-	-	-	236,566	66,277	302,843	878,870	153,449	1,032,319			-			-			-			-	1,115,436	219,726	1,335,162
6		**Pharmacy**																							
	25	**Total Pharmacy**			-	560,457	63,013	623,470	2,500,130	482,738	2,982,868			-			-			-			-	3,060,587	545,750	3,606,337
7		**Medical/Surgical other than primary care**																							
	26	In-state	107	-	107	500,447	25,883	526,330	1,872,922	107,942	1,980,864			-			-			-			-	2,373,477	133,824	2,507,301
	27	Out-of-state	-	-	-	100,752	54,851	155,604	328,431	377,542	705,973			-			-			-			-	429,183	432,394	861,577
	28	**Total Other Medical/Surgical (Lines 26 + 27)**	107	-	107	601,200	80,734	681,934	2,201,353	485,484	2,686,837	-	-	-	-	-	-	-	-	-	-	-	-	2,802,660	566,218	3,368,878
8		**All other payments to medical providers**																							
	29	**Total**	133	-	133	240,951	41,780	282,732	1,082,028	206,290	1,288,317			-			-			-			-	1,323,112	248,070	1,571,182

2012 Rate Review Process
Areas of Medical Expense Variation

Introductory Remarks

The stated goal of this exercise is to improve OHIC's understanding of the drivers of rising medical spending in Rhode Island by comparing the experience of the issuer's Rhode Island member base to a benchmark. For the purposes of this analysis, we have used our 2011 fully insured MA HMO experience as the benchmark. However, given the size of Tufts Health Plan's membership base in Rhode Island, the results of this comparative analysis will have limited credibility. Our relative costs by area of care have changed significantly in Rhode Island from year to year and are expected to continue to be volatile as our population in this market grows. Although we have commented on the probable causes of each variation listed, these fundamentally reflect a small, immature market compared to a much larger, more mature benchmark and should be interpreted with caution.

1. The top five areas of care, based on *per capita total dollar value* positive variation from the benchmark

Area of Care	Total Excess Spending	PMPM Excess Spending	Comments on Estimated Cause
INPATIENT ACUTE MED/SURG	$1,339,638	$23.29	Attributable to higher utilization (both admits and ALOS), rather than unit cost. High cost claimants identified as having a disproportionately large impact. The higher number of admits may be a consequence of lower than benchmark outpatient professional care.
PHARMACY - Rx MM	$717,042	$12.46	Attributable to higher utilization across tiers and therapeutic classes. Higher utilization driven by more members in RI having prescriptions filled than in the benchmark population, rather than a higher number of prescriptions per member.
OUTPATIENT LABORATORY	$558,538	$9.71	Capitation strategy applied in the benchmark population successfully contains cost.
OUTPATIENT INJECTIONS	$425,609	$7.40	Driven primarily by a difference in payment methodology between RI and the benchmark population. Injection claims in RI are reimbursed on a fee for service basis while in the benchmark population they are reimbursed on a fee for service basis or bundled into an outpatient surgery case payment. More than 50% of the higher RI utilization is associated with outpatient surgery claims, which would not be separately identified in the benchmark population.
OUTPATIENT EMERGENCY ROOM	$406,508	$7.07	Attributable primarily to a higher cost per emergency room encounter. This higher cost per encounter is driven less by higher unit cost in RI and more by the higher number of services delivered within an emergency room encounter compared to the benchmark.

2. The top five areas of care, based on *the percent of positive variation in per capita spending* from the benchmark

Area of Care	Percent of Positive Variation	Total Excess Spending	Comments on Estimated Cause
OUTPATIENT INJECTIONS	158%	$425,609	Driven primarily by a difference in payment methodology as described above.
FREE STANDING HIGH COST RADIOLOGY (MRI, PET, CT)	124%	$130,764	Higher utilization of allied health facilities, along with lower Outpatient Hospital High Cost Radiology utilization, reflects appropriate re-direction of care to lower cost providers.
OUTPATIENT LABORATORY	96%	$558,538	Capitation strategy applied in the benchmark population successfully contains cost.
INPATIENT OTHER	74%	$117,886	Driven by Mental Health/Substance Abuse services. Capitation strategy for inpatient Mental Health/Substance Abuse within the benchmark population effective at containing costs.
OUTPATIENT EMERGENCY ROOM	63%	$406,508	Attributable primarily to the number of services delivered within an emergency room encounter, as described above.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Provider Contracting Practices and Hospital Contracting Conditions Verification Questionnaire

Background

The Health Insurance Advisory Council (HIAC) to the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) has promulgated Affordability Standards for commercial health insurance issuers in Rhode Island.

Health plans will improve the affordability of health care in Rhode Island by focusing their efforts upon provider payment reform, beginning with primary care. Achievement of this goal will not add to overall medical spend in the short-term, and is expected to produce savings thereafter. Specific areas of focus in support of this goal are as follows:

1. Expand and improve the primary care infrastructure in the state—with limitations on ability to pass on cost in premiums
2. Spread Adoption of the "Chronic Care Model" Medical Home
3. Standardize electronic medical record (EMR) incentives
4. Work toward comprehensive payment reform across the delivery system

To support standard four, OHIC has previously issued six conditions for issuer contracts with hospitals in Rhode Island, to be implemented by issuers upon contract execution, renewal, or extension. These are as follows:

1. Utilize unit of service payment methodologies for both inpatient and hospital outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee for service.
2. Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index ("Index"), for all contractual and optional years covered by the contract
3. Provide the opportunity for hospitals to increase their total annual revenue for

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

commercially insured enrollment under the contract by at least additional two percentage points over the previous contract year by improving or attaining mutually agreed-to performance levels for no less than three nationally-accepted clinical quality, service quality or efficiency-based measures.

4. Include terms that define the parties' mutual obligations for greater administrative efficiencies
5. Include terms that promote and measure improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers.
6. Include terms that explicitly relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement.

The purpose of this questionnaire is to assess compliance with standard four of the Affordability Standards and to consider the responses in connection with OHIC's 2012 small and large employer group rate factor review process for commercial health insurance issuers in Rhode Island.

Directions

1. Please fill out all parts of questionnaire.
2. As no providers are identified and no financial details are solicited, none of this information will be considered proprietary or confidential. Should any information or document be considered confidential by the filer, the filer must request approval of the Health Insurance Commissioner. The request must identify the specific information or document (or portion thereof) which the filer considers confidential, accompanied by a factual and legal analysis supporting the request.
3. Questionnaire responses must be verified by filing those portions of each hospital contract which support the survey response. An index or other method of reference must be included to identify which hospital contract documentation relates to each survey response. Any contract excerpts provided will be summarized for review.
4. Please contact OHIC with any questions.

State of Rhode Island Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920-4407
(401) 462-9640
(401) 462-9645 (Fax)
www.ohic.ri.gov
THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

General comment:

Tufts Health Plan has a long standing commitment to investment in payer-provider incentive alignment, and we maintain hospital and physician incentive programs that apply to the vast majority of our network providers. As a relatively new entrant into the RI market, we are at an early stage of incorporating incentive mechanisms into our RI provider contracts. Provider incentive will be a key component of our contracting strategy as we grow our presence in the state of RI.

Tufts Health Plan requests that the information provided in response to this survey be deemed to constitute "trade secrets" within the meaning of the term in section 38-2-2(4)(i)(B) of the Rhode Island General Laws. We have included a footer stating "THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION".

Finally, due to the questionable reliability of certain information provided in our responses, which is explained in further detail below, it is Tufts Health Plan's expectation and understanding that the information provided in this Provider Survey will not be used or considered in OHIC's review of Tufts Health Plan's rates.

Part 1. Hospital Inpatient Services

- **Please fill out one row in the chart below for <u>each</u> general service institution (no specialty care, no rehab) with whom you contract in RI.**
- **Institution means hospital system if all contractual terms other than $ amounts apply identically across all inpatient facilities in the contract.**
- **Incentives refer to activities or measures resulting in additional payments by the insurer.**

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments

[1] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[2] Attach analysis and relevant documentation from contracts to demonstrate compliance status.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
1	3 Years	X DRG X Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	No	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [3]	__ admission reductions __ day reductions __ process/structural changes (e.g. discharge practices) __Others (please specify)	N/A (Contract has not been renegotiated)	
2	3 Years	x DRG x Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.5~1.0%____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
3	3 Years	__DRG __Per Diem x % of Charges __ Bundled Services	No	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

[3] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
		__ Capitation or other budgeting __Others (please specify)		incentive payments. 0.1~0.5%			
4	2 Years	__DRG x Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
5	3 Years	__DRG __Per Diem x % of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	No	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
6	3 Years	__DRG __Per Diem x % of Charges __ Bundled	No	No If yes - % of total payments for inpatient services in CY	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2011 Rate Factor Decision – Additional Conditions?[2]	Comments
		Services __ Capitation or other budgeting __Others (please specify)		2011 spent on quality incentive payments. _____			
7	1 Year	__DRG _x_Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. ____ 0-2%	_X_ admission reductions _X_ day reductions __Others (please specify)	Yes, please see attached	
8	3 Years	__DRG _x_Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

Additional Questions for Hospital Inpatient Services

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

1. List the five most common areas of quality and service incentives in your company's inpatient contracts:
(These measures apply to our hospital contracts that combine inpatient and outpatient services.)
   i. Joint Commission measures (e.g., AMI, CHF, pneumonia)
   ii. Leapfrog measures (e.g., CPOD, ICU staffing)
   iii. Prevention of "Never Events"
   iv. Surgical infection rates
   v. Readmission rates
2. Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2011 spent on quality incentive payments. 0.1~1%

3. Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2011 paid through units of service based on efficient resource use (i.e DRG, Capitation, Bundled Service or partial/global budgeting): <5%

4. Estimated Payments in first six months of CY 2011 for Inpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: See comment (add comments or caveats)

   For inpatient services Tufts Health Plan does not currently have the technical capability to benchmark to Medicare IPPS reimbursement. Conducting such analysis would require incremental time, resources and technical capabilities. Benchmarking Tufts Health Plan inpatient payments to Medicare IPPS may yield volatile and potentially unreliable results due to a) differences in reimbursement methodology (Tufts Health Plan reimburses the majority of inpatient claims on either a Per Diem or Percent of Charge basis); b) our relatively small volume of business in Rhode Island; c) mix of services; and d) chargemaster levels to some of the hospitals in Rhode Island. Additionally, it is our belief that a Medicare comparison for some hospitals that perform very specific services, like Obstetrics, will not result in a comparison that is useful and may lead to unintended and/or misinterpreted conclusions.

Other Comments on Quality/Efficiency Incentives in Hospital Inpatient Contracting:

Part 2. Hospital Outpatient Services

- **Please fill out one row in the chart below for each general service institution (no specialty care, no rehab) with whom you contract in RI.**
- **Institution means hospital system if all contractual terms other than dollar amounts apply identically across all inpatient facilities in the contract.**
- **Outpatient Services include any services not involving an admission and covered under the contract with the institution.**

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[4]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - %of total payments for inpatient services in CY 2011 spent on quality incentive payments. [5]	__ Visit/Volume Reduction __ Others (please specify)	
2	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.5~1.0%____	__ Visit/Volume Reduction __ Others (please specify)	
3	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0.1~0.5%	__ Visit/Volume Reduction __ Others (please specify)	
4	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality	__ Visit/Volume Reduction __ Others (please specify)	

[4] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[5] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[4]?	Utilization Incentives in Contract: (check all that apply)	Comments
		incentive payments. _____		
5	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
6	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
7	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
8	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	

Additional Questions for Hospital Outpatient Services

1. List the five most common areas of quality and service incentives in your company's hospital outpatient contracts:

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

(These measures apply to our hospital contracts that combine inpatient and outpatient services.)

i. Joint Commission measures (e.g., AMI, CHF, pneumonia)
ii. Leapfrog measures (e.g., CPOD, ICU staffing)
iii. Prevention of "Never Events"
iv. Surgical infection rates
v. Readmission rates

2. Percent of total payments to RI Hospitals for outpatient services in CY 2011 spent on quality incentive payments. 0.1~1%

3. Percent of total payments to RI Hospitals for outpatient services in CY 2011 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): n/a

4. Estimated Payments in first six months of CY 2011 for Outpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: 222% (i.e. 122% over Medicare Reimbursement) (add comments or caveats)

   For Outpatient Services, Tufts Health Plan has the technical capabilities to perform the required benchmarking analysis to Medicare; however, we have concerns about the confidence level in the accuracy of the supplied benchmark. Our concerns are due to a) the allowed reimbursement at a claim level was compared to fee information obtained from OPPS and CMS ancillary schedules such as Clinical Lab, DME etc.; b) we are not able to reprocess our claims through an OPPS Grouper and were limited to a line level reprice based on OPPS/Ancillary fees which means that exact Medicare reimbursement can only be approximated; c) Procedures that do not have a fee on OPPS/Ancillary schedules, or are billed in a different manner to Medicare (e.g., observation) were dropped from the analysis.

   Additionally, Tufts Health Plan has concerns that the results may be skewed due to a few high-volume hospitals and the large number of providers reimbursed on a percent of charges basis – factors that may distort the data due to particular mix of services and chargemaster levels of PAF providers. Based on the concerns listed above it is our belief that a Medicare comparison might not result in a benchmark that is useful and could lead to unintended and/or misinterpreted conclusions that if made public could impact certain contract negotiations by putting upward pressure on unit costs.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Other Comments on Quality/Efficiency Incentives in Hospital Outpatient Contracting:

Part 3: Professional Groups

- **"Professional Groups" is defined as non institutional/non facility groups with a valid contract and a single tax id number.**
- **Please provide information for the top 10 groups (measured by $ paid in 2011), filling in one row per group (10 rows in the table total).**

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	Multi-specialty	x Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. [7] _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services _ Others (please specify)	
2	Multi-specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
3	Multi-specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code	No If yes - % of total payments for inpatient services in CY 2011 spent	__Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care	

[6] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.
[7] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
		__ Full/ Partial Capitation __Other (please specify)	on quality incentive payments. _____	__ use of pharmacy services __ Others (please specify)	
4	Sub - Specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
5	Primary Care	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
6	Primary Care	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	Yes If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. 0~5%	x Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care x use of pharmacy services x Others (please specify)	Quality/Member Satisfaction
7	Sub - Specialty	_ X _ Procedure-based methodology – using CPT, plan,	No	__ Visit/Volume Reduction __use of ancillary/referred services	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
		provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments.	__ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
8	Sub - Specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
9	Multi-specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	
10	Multi-specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - % of total payments for inpatient services in CY 2011 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ overall efficiency of care __ use of pharmacy services __ Others (please specify)	

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Additional Questions for Professional Groups

1. List the five most common areas of quality and service incentives in your company's professional group contracts:
   i. HEDIS (diabetes, breast cancer screening, colonoscopy, etc.)
   ii. HCHAPS
   iii. EMR adoption
   iv. Inpatient and ER use
   v. Rx Management
2. Percent of total payments to these ten professional groups in CY 2011 spent on quality incentive payments. ___<1%_____

3. Percent of total payments to these ten professional groups in CY 2011 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): ___n/a_____

4. Estimated Payments in first six months of CY 2011 for Professional Group Services as % of what Medicare would have paid for similar set. of services: 122% (i.e. 22% over Medicare Reimbursement) (add comments or caveats)

   The analysis was conducted using a claim line level comparison between allowed reimbursement and Medicare fee information obtained from RBRVS tables as well as Medicare ancillary schedules such as clinical lab, DME etc. Anesthesia services were also included. Procedures that Medicare does not reimburse but supplies RVU information for, such as preventive medicine and consults codes, are included at the RVU level rate for the Medicare comparison. Claims lines that do not have RBRVS/Ancillary schedule information were dropped from the analysis.

   Additionally, Tufts Health Plan has concerns that the results may be skewed due to particular mix of services for providers. Based on the concerns listed above it is our belief that a Medicare comparison might not result in a benchmark that is useful and could lead to unintended and/or misinterpreted conclusions that if made public could impact certain contract negotiations by putting upward pressure on unit costs.

Other Comments on Quality/Efficiency Incentives in Professional Group Contracting:

Selected Contract Sections Showing Compliance To OHIC Conditions

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

Effective for dates of service on or after January 1, 2011

Office of the Health Insurance Commissioner Conditions

Pay-For-Performance: **[Redacted]** is available for the Hospital to earn based upon quality and/or efficiency measures **[redacted]**.

Case Rates: In the event **[redacted]** parties agree to meet to discuss the potential to transition to efficiency based payment methodologies (e.g., DRG, APC) in a manner that **[redacted]**.

Administrative Efficiency: Tufts Health Plan agrees to assign a Contract Specialist to provide ongoing contract related support through the term of the agreement to help mitigate contract related issues.

The Hospital agrees to work with and communicate issues to the Contract Specialist on an ongoing basis and work in good faith to resolve contract related issues in a timely manner.

Communication: During calendar year 2011 parties agree to formalize clinical communication that promotes and measures improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers.

Public Release of Contract Terms: Parties agree to allow the public release of terms outlined in this agreement if compelled by State regulatory authorities.

THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION

1. Please provide an excel spreadsheet in the following format, detailing the 2011 actual and 2013 requested small and large group administrative costs pmpm, allocated among the NAIC- financial statement administrative cost categories. Please explain any significant changes from the financial filing for 2011 (increases/decreases of more than five percent in a particular category).

RI Insured PPO	2011 Actual (from filed financial statements)		2013 Proposed		% Change	
	Small Group	Large Group	Small Group	Large Group	Small Group	Large Group
Total Estimated Member Months	6,778	28,008	5,732	26,480	-15.4%	-5.5%
Total Estimated Premiums ($pmpm)	$382.46	$404.51	$422.41	$446.68	10.4%	10.4%
Total General Administrative Expense	$37.84	$37.94	$41.93	$39.72	10.8%	4.7%
Total Cost Containment Expense	$10.43	$9.64	$11.65	$11.65	11.7%	20.8%
Total Other Claim Adjustment Expense ($pmpm)	$7.99	$7.38	$8.92	$8.92	11.7%	20.8%
Breakdown of General Administrative Expense ($pmpm)						
a. Payroll and benefits	$2.94	$2.72	$3.29	$3.29	11.7%	20.8%
b. Outsourced Services (EDP, claims etc.)	$0.09	$0.09	$0.10	$0.10	11.7%	20.8%
c. Auditing and consulting	$8.02	$7.42	$8.96	$8.96	11.7%	20.8%
d. Commissions	$13.32	$14.30	$14.24	$12.03	6.9%	-15.8%
e. Marketing and Advertising	$1.76	$1.63	$1.97	$1.97	11.7%	20.8%
f. Legal Expenses	$0.17	$0.16	$0.19	$0.19	11.7%	20.8%
g. Taxes, Licenses and Fees	$8.72	$9.22	$10.21	$10.21	17.1%	10.7%
h. Reimbursements by Uninsured Plans	$0.00	$0.00	$0.00	$0.00	0.0%	0.0%
i. Other Admin Expenses	$2.82	$2.42	$2.97	$2.97	5.4%	22.7%

Notes

1. The expense in any given administrative category may vary from year to year due to the small size of Tufts Health Plan's PPO block of business in Rhode Island. In aggregate, however, total admin has increased less than about 3% per year.

2. Please also provide an excel spreadsheet in the following format; detailing actual calendar year 2007-2011 fully insured commercial administrative costs, in accordance with the following table. This should be consistent with the annual statement filings to OHIC for administrative costs, providing additional detail on the components of administrative costs using the categories defined by NAIC financial statement and as allocated to commercially insured business only. Specifically, the information provided should agree with the "Exhibit of Premiums, Enrollment and Utilization" and the "Analysis of Operations by Line of Business" schedules included in the Annual Statements on file with OHIC. Where there are variance, a reconciliation and explanation should be provided.

Fully Insured Commercial Administrative Cost History

RI Insured PPO	2007	2008	2009	2010	2011
Total Premiums			12,373,810	17,393,107	13,921,729
Total General Administrative Expense			1,929,424	1,887,787	1,319,190
General Admin Exp. Ratio			15.6%	10.9%	9.5%
Total Fully Insured Member Months			33,738	45,416	34,786
General Administrative Expense ($pmpm)			$57.19	$41.57	$37.92
Breakdown of General Administrative Expense ($pmpm)					
a. Payroll and benefits			$3.37	$2.49	$2.76
b. Outsourced Services (EDP, claims etc.)			$0.01	$0.01	$0.09
c. Auditing and consulting			$5.92	$4.93	$7.54
d. Commissions			$18.10	$16.49	$14.11
e. Marketing and Advertising			$2.52	$1.72	$1.66
f. Legal Expenses			$0.08	$0.11	$0.16
g. Taxes, Licenses and Fees			$7.34	$8.74	$9.12
h. Reimbursements by Uninsured Plans			$0.00	$0.00	$0.00
i. Other Admin Expenses			$19.85	$7.09	$2.50
Cost Containment Expense			179,767	385,924	340,764
Other Claim Adjustment Expense			236,579	369,709	260,894
Total Self Insured Member Months for all Affiliated Companies doing business in RI			113,694	0	662

RI Insured PPO

3. At the request of OHIC's Health Insurance Advisory Council, please provide brief answers to the following questions

- **In general and net of new taxes and fees, why should the rate of increase in Health Plan administrative costs exceed the general inflation rate?**

  Administrative expenses in total in a given year are adjusted for inflation, membership growth or loss and increases or decreases in corporate projects, which are often driven by regulatory requirements and government mandates. As a general practice, to set administrative expense targets for the annual financial plan, fixed administrative costs are grown at an inflationary rate. Variable administrative costs are then developed by applying inflation to the variable pmpm rate and then multiplying the inflated pmpm rate by planned member months. While those are the initial steps to develop targets, each administrative function is reviewed in detail to identify potential administrative cost savings and targets are adjusted accordingly.

- **What percentage of administrative costs does your organization consider fixed for the next five years? Provide detail by expense categories.**

  For the total company, we currently consider 58% of our costs fixed as follows:

Fixed Administrative Costs by Category:	
Network Management	2%
Sales and Marketing	4%
Clinical Services	5%
Operations	5%
IT & Business Effectiveness	8%
Corporate Projects	14%
Fixed Overhead and Other	20%
Total Fixed Administrative Expenses	58%

- **What administrative services are used by fully insured members that are not used by self-insured clients (e.g. broker commissions) and what are the estimated total costs ($pmpm) for those services?**

  Administrative costs for fully insured membership include expenses associated with medical cost containment ($9.80 pmpm), whereas in most cases self-insured clients bear these costs directly. Broker commissions ($14.11 pmpm) are also not applicable to most self-insured clients.

- **What does your plan use as its pmpm benchmarks or price points for commercial insurance administrative costs and why?**

We periodically participate in the benchmarking survey used to develop the *Sherlock Expense Evaluation Reports* (SEER) which are viewed as the definitive benchmarks for the functional areas of health plan administration. The Sherlock Expense Evaluation Reports (SEER) supply comprehensive and highly granular financial and operational metrics.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Health System Improvements Survey

The State of Rhode Island Office of the Health Insurance Commissioner Regulation 2 lists standards to be used by the Health Insurance Commissioner (Commissioner) for the assessment of the conduct of commercial health insurance issuers in Rhode Island for their efforts aimed at improving the efficiency and quality of health care delivery and increasing access to health care services. The standards include the following issuer activities:

1. Directing resources, including financial contributions, toward system-wide improvements in the state's health care system related to quality, access and efficiency, including providing support to local collaboratives, organizations, and initiatives that promote these three goals

2. Participating in the development and implementation of public policy issues related to health

To assist the Commissioner in this assessment, as part of the 2012 small and large employer group rate factor review process for commercial health insurance issuers in Rhode Island, please itemize and quantify your organization's contributions of finances and other material assets to these efforts in Rhode Island in calendar year 2011 in the following table.[1]

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
Funding	Grants provided by the Tufts Health Plan Foundation and Community Relations to the following RI organizations to support wellness and safety initiatives • **Best Buddies International** *Best Buddies Intergenerational College Project* Grant Amount: $20,000 • **Mount St. Rita Health Centre** *Blessings in a Back Pack* Grant Amount: $5,000 • **Bethany Home of Rhode Island Inc.**	**$515,724**

[1] The contributions can be to any entity other than a provider to improve medical and prevention services for all Rhode Islanders and to promote a coherent, integrated, and efficient statewide health care system.

State of Rhode Island Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920-4407
(401) 462-9640
(401) 462-9645 (Fax)
www.ohic.ri.gov

System-wide Improvement Activity	Brief Description of Activity and How it Promotes Health Care System Quality, Access or Efficiency	Value of 2011 Issuer Contributions
	Bethany Home Cares Grant Amount: $43,036 • **Homefront Health Care** *HIP-SAFE (Homefront Intervention to Prevent Slips & Falls in Elders)* Grant Amount: $59,438 • **Rhode Island Free Clinic Inc.** *Healthy Lifestyles for Today and Tomorrow* Grant Amount: $60,000 • **The Providence Center** *InShape Seniors* Grant Amount: $42,000 • **Ocean State Center for Independent Living (OSCIL)** *Home Sweet Accessible Home* Grant Amount: $40,000 • **Westbay Community Action Inc.** *Elder Safety* Grant Amount: $42,000 • **Rhode Island Quality Institute** *Health Information Exchange Support* Grant Amount: $25,000 • **EMR Payments** $179,250	

Participation in RI initiatives, programs and organizations	The goals of these programs, initiatives and organizations is to improve quality and/or transform primary care in the state:
	• CSI/Beacon (Project director, project manager, and nurse case manager support) $38,329
	• Value of Resource Time in Various Programs (Estimate of $30,000 for 0.2 FTE for 2011)
	  ○ RI DOH Medical Director meetings
	  ○ RI Quality Partners Safe Transitions
	  ○ RI Senate Commission on Hospital Payment Reform
	  ○ RIQI Board of Directors
	  ○ RI CSI Beacon Executive Committee
		$68,329

Thank you for your cooperation.